ORIENTATION TO SPECIAL EDUCATION ACADEMY

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04-16-02

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Academy Introduction

Using the **Orientation to Special Education Academy** transparency **(T1)**, review the modules with the paraeducators before beginning the academy along with the following.

This academy is designed to provide a basic introduction to special education and the needs of students who have disabilities. The content consists of introductory material regarding legal and historical foundations of special education, human growth and development, the nature of disabilities, and an introduction to the basic human needs that paraeducators must address.

Please note that some of the material contained in this academy refers specifically to the state of Colorado. If the academy is being taught elsewhere, it will be necessary to obtain comparable information for the location the academy is being taught in.

Module A: History, Legal Precedents, and Values

- *Know major laws and court rulings that have helped shape special education services.*
- *Know the legal rights of students with disabilities and the qualification processes for special education services and 504 plans.*
- *Know the steps and processes of special education services in Colorado.*
- *Articulate the values and rationale for inclusion of students with disabilities into general education.*

Module B: Overview of Human Growth, Development, and Learning

- *Identify major cognitive, affective, physical, and communicative milestones of typically developing children and youth.*
- *Know basic styles of human learning.*
- *Know the risk factors that may prohibit or impede typical development.*

Orientation to Special Education (continued)

Module C: Overview of Exceptionalities

- ***Know how beliefs about people with disabilities are related to life experiences.***
- ***Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.***
- ***Know categories of exceptionality according to state and national laws.***
- ***Recognize the cognitive, communicative, physical, or affective needs that students may have as a result of a disability.***
- ***Know how to access information about specific disabilities, syndromes, and medical conditions on the internet, through libraries, and other sources.***

Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities

- ***Know written health, safety, and emergency procedures and practices.***
- ***Know responsibilities and practice associated with maintaining the physical health and safety of students.***
- ***Know the obligation of all school personnel to report child abuse, suicidal ideation, and/or dangerous behavior.***
- ***Know techniques that promote interactions and facilitate friendships among students with and without disabilities.***

Module A: History, Legal Precedents, and Values

Orientation to Special Education
Module A: History, Legal Precedents, and Values

A. Energizer

Have the paraeducators fill out name tags and introduce themselves to the group. Introduce yourself and give them a brief overview of your background.

B. Module Goals

Using the **Module A: History, Legal Precedents, and Values** handout and transparency **(H1/T1)**, review the goals of the module.

1. Know major laws and court rulings that have helped shape special education services.
2. Know the legal rights of students with disabilities and the qualification processes for special education services and 504 plans.
3. Know the steps and processes of special education services in Colorado.
4. Articulate the values and rationale for inclusion of students with disabilities into general education.

Note to Instructor: It is to the benefit of the participant to be familiar with their district's IEP. Please make transparencies and handouts as needed for Goal 2.

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Goal 1: Know major laws and court rulings that have helped shape special education services.

1.1 Activity: Knowledge Assessment

Paraeducators will participate in an activity that will provide them and the instructor with information regarding the current level of knowledge and information they have regarding history and law affecting special education.

1.1.1 Steps

- Present the **Knowledge Assessment** handout and transparency **(H2/T2)**. Explain that this is not a test, but a tool to find out how much they already know about the laws and court rulings that have shaped special education.
- Give the participants time to briefly answer the questions.
- When finished, ask the group to share their answers. Emphasize that all of the questions will be covered during the course of the module. Suggest they use the handout to take notes on during the session.

1.2 Lecture: Historical Perspective

Present the **Historical Perspective** handout and transparency **(H3/T3)**.

Early History

- There were fewer people with disabilities due to lack of medical services, often children who were born with severe problems did not survive.
- In early civilizations, children born with a disability were often put to death or allowed to die.
- Early references document that blindness and deafness have always existed and that much superstition and misunderstanding have been associated with handicapping conditions.
- There is documentation that indicates that people with disabilities were kept as "fools" for entertainment.
- In some places, there was the belief that differences were caused by devils, demons, or were some kind of omen.
- Christianity had an effect in some places. An attitude of love toward

humans affected the treatment of people with differences, but in some cases individuals with handicapping conditions were still viewed as nonhuman, as fools, or as witches (exorcism was even used in some places).

- In the late 1500s, a Spanish monk, Pedro Ponce de Leon, was successful in teaching deaf pupils to speak, read, and write.
- Around the mid 1700s, Abbe' de L' Eppee opened a school for the deaf in Paris and his associate Huay opened a school for the blind after witnessing the exploitation of several blind men in the street.
- Around 1800, the Wild Boy of Aveyron was found. He was a boy of 11 to 12 years of age and was found roaming wild, animal like, and scared. He behaved like an animal and chose his food by smell. He may have been the survivor of parental abandonment. He was taught to be civilized with minimal success. This event helped to focus attention on teaching the mentally retarded.

Era of Institutions (1800 - 1900)

- In Europe, asylums were built which housed people with mental retardation, mental illness, and epilepsy. Conditions were often dehumanizing, filthy, and crowded.
- In the United States, prisons often held people with mental illnesses or mental retardation. People with handicapping conditions seemed to blend into the community more in rural areas.
- By the mid 1800s, special schools were started for those with mental retardation. These schools were set apart from other public schools. The schools developed into large institutions, a policy which prevailed for a long time. Most of these institutions were built outside of cities and offered little community interaction. Maltreatment often occurred in these institutions, mainly because the public did not want to deal with these people.
- Public funds were not generous, so there was little attempt at schooling.
- In the mid 1800s, Klein suggested that the blind should be in regular schools. He was disregarded by all but a few.

Era of Public Schools: Special Classes

Use the **History of American Schools** handout **(H4)** to supplement this portion of the lecture.

- In 1898, Alexander Graham Bell, in an address to the National Educational Association (NEA), suggested that we should have annexes to regular schools for students with handicapping conditions.

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- The National Association for Retarded Children, founded in the early 1950s, was an advocacy group that focused on the need to provide services that would allow people with disabilities to live at home and receive an education.
- The special schools for the mentally retarded had as their goal to return the individuals to "normalcy," and, therefore, were fairly unsuccessful.
- Schools for the blind and/or deaf appeared later because the institutions set up for them tended to be more educationally oriented. The urgency wasn't as great.
- With the enactment of compulsory school attendance laws in the early 1900s came the problem of what to do with individuals who had more mild mental retardation. At first, many districts attempted to educate the mildly retarded within the regular classroom setting. The practice of failing or holding them in a given class until they could do the work was often used. Behavior problems ensued and special classes evolved.
- Schools that did accommodate for the needs of children who were mentally retarded often did so without a systematic plan for assessment, placement, or parental involvement.

Era of Accelerated Growth

- All children are recognized as having the right to have an equal opportunity to education (Brown v. Board of Education, Kansas 1954).
- All children have the right to fair assessment in their native language (Diana v. CA Board of Education, CA 1970).
- All children and their parents have the right to participate in major decisions affecting the child. This case helped to establish that all children have the right to an education. Public schools must provide an appropriate education to all children, in their own facilities or by arrangement with other agencies. (Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania, Pennsylvania 1971)
- All children have the right to an education at public expense regardless of the school district's financial constraints. No child can be excluded from regular public school unless the local district finances the child's education within special classes, private schools, or with tutors. No matter how severe the handicapping condition of the child, the public school system must provide education services and must demonstrate their adequacy. (Mills v. Board of Education of the District of Columbia, District of Columbia 1972).

Major legislation that has extended and clarified the legal rights of person's with disabilities.

Note to Instructor: These are the most important laws for the students to become familiar with and understand.

- 1965: PL 8910 Elementary and Secondary Education Act (ESEA)
  - Provided funds to state agencies and local school districts for developing programs to serve economically disadvantaged and handicapped students.
- 1973: PL 93-112 Vocational Rehabilitation Act (Section 504)
  - The first federal civil rights law that specifically protected the rights of individuals with handicapping conditions. The law established rights of individuals with handicapping conditions for nondiscrimination in employment, admission into institutions of higher learning, and access to public facilities. All students who are covered under IDEA are also covered under Section 504. However, there are numerous conditions that are not eligible for special education services under the 13 IDEA categories, but that can receive services under Section 504. Section 504 services are coordinated and funded through regular education programs.
- 1975: PL 94-142 Education for All Handicapped Children Act (EHA)
  - Mandated a free, appropriate, public education for all children with handicapping conditions in the least restrictive environment without regard to the type or severity of the handicap. Also outlined rights of children with handicapping conditions and their parents including procedures for due process, nondiscriminatory testing, program placement, use of records, etc.
- 1986: PL 99-457 Education of Handicapped Act Amendments
  - Reauthorized sections of PL-142. Mandated three- to-five-year-old services and extended programs for infants and toddlers with handicapping conditions.
- 1990: PL 101-336 The Americans with Disabilities Act (ADA)
  - Provided a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities by prohibiting discrimination in employment, public services, public accommodations and transportation, and providing telecommunication relay services.
- 1990: PL 101-476 The Education of the Handicapped Act Amendment of

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1990 (IDEA)

- This law changed the name of EHA to the Individuals with Disabilities Education Act (IDEA). This law reauthorized and expanded the discretionary programs, mandated transition services and assistive technology services to be included in a student's IEP, and added autism and traumatic brain injury to the list of categories of children and youth eligible for special education and related services. The list of different disabilities served in public schools:
  - Autism;
  - Deafness;
  - Deaf-blindness;
  - Hearing impairment;
  - Mental retardation;
  - Multiple disabilities;
  - Orthopedic impairment;
  - Other health impairments;
  - Serious emotional disturbance;
  - Specific learning disability;
  - Speech or language impairment;
  - Traumatic brain injury; and
  - Visual impairment, including blindness.

1997: P.L. 105-17 The Individuals With Disabilities Education Act (reauthorization of IDEA, signed into law June 4, 1997)

- This reauthorization of IDEA introduced a number of important changes into existent special education law. Major changes reflected in the law were:
  - Evaluation
    - Must include information related to enabling the child to be involved in and progress in general education.
  - Re-evaluation
    - Parental consent required, unless parent fails to respond to reasonable request.
    - New testing only in areas where additional data is required.
  - Eligibility
    - Parent to be given a copy of the evaluation report and documentation of determination of eligibility.
  - IEP

- Must address general curriculum in all major parts: current functioning, services, and goals.
- Regular educator required to attend.
- Must address whether or not the student will participate in state assessments, what modifications are modifications, and how the student will be accountabile.

⇉ Transition
- Beginning at age 14.
- Address course of study.
- One year before age of majority, the student must be informed of rights transfer.

⇉ Progress Reports
- Must be given as frequently to parents as reports of progress are for students who are non-disabled.

⇉ Parent Rights
- Must be sent out with all notices and when parents file due process.

⇉ Discipline
- If a student in special education is removed from their current placement due to behavioral concerns, the team must perform a functional-behavioral assessment and develop a behavioral intervention plan (or review and modify the current one).

⇉ ***Paraeducators***
- Paraeducators and assistants who are appropriately trained and supervised can assist in the provision of special education and related services.

1.3 Activity: Rights to Special Education in Colorado

Paraeducators will participate in an activity analyzing and examining the rights to special education in Colorado.

Note to Instructor: Many states have their own or similar material regarding the rights of those involved in the special education process. If the academy is being taught outside of

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Colorado, locate and use the information for that specific state.

1.3.1 Steps

- Divide the class into groups of four.
- Distribute the **Handbook of Rights to Special Education in Colorado: A Guide for Parents** handout **(H5)**, giving each group a section of the handbook.
- Have the groups read, review, and discuss their section.
- When finished, have each group share their section with the class.
- For general information and reference, distribute the **Special Education Language Key** handout **(H6)**.
  - ➥ *Source: Information adapted from Gearheart @ Weishahn, 1976; Hallahan @ Kauffman, 1986; Morsink, 1984; and Pickett @ Formanik, 1986.

Goal 2: Know the legal rights of students with disabilities and the qualification processes for special education services and 504 plans.

2.1 Lecture: Six Major Principles of Student Rights

Use the **Six Major Principles of Students Rights** transparency and handout **(H7/T4)** to facilitate the lecture.

Zero Reject

- Every school-age individual must be served, and services must be provided at no cost to families. The state must have a program (often known as Child Find) for identifying populations of children who are eligible for special services.

Testing, Evaluation, and Placement

- Prescribed methods for nondiscriminatory evaluation and appropriate placement must be followed.

Individualized and Appropriate Education

- Programs must be individualized to meet the specific needs of each child. This is probably the most critical principle for building administrators and teaching staff. The IEP serves as a record that each student's needs and abilities have been considered and addressed individually.
- Each student is assessed in the child's native language.
- Long-range and short-range objectives are set according to each student's needs.
- The student's progress is evaluated on a regular basis.
- A range of service options are available to the student and his/her family.
- A continuum of placement options exist that utilize the least restrictive environment (LRE) principle, from placement in general education with the provision of supplementary aids and services to placement in separate classrooms or facilities and homebound services.

Least Restrictive Placement

- This stipulates that students with handicapping conditions be educated to the greatest extent feasible in the company of their peers who are not handicapped.
- It is not required that every student with a handicapping condition be placed in a regular class or school, but all IEP teams must begin with an

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assumption in favor of an inclusive program.

- The availability of a continuum of placement options is required ranging from placement in general education with supplementary aids and services to placement in separate classrooms and homebound services.
- Placement decisions cannot be based on one individual assessment or on one test.
- The student's individual needs determine placement as specified in the student's IEP.
- Educators use a team approach. Parents, teachers, paraeducators, and related service providers make placement and programmatic decisions, and share information to help make each student's educational program effective and consistent. These related services may include counseling, social services, special transportation, speech/language therapy, vision services, services for hearing impairments, and occupational or physical therapy.

Procedural Due Process

- The right of parents to protest state or local school district actions that they find discriminatory, inappropriate, or unfair is derived from the U.S. Constitution and is essential to ensuring that the provisions of the law are carried out.

Parent Participation and Shared Decision Making

- P.L. 94-142 involves the student's parents (or legal guardians or appointed surrogates) at each stage of the legally defined special education process. For example, parents or legal guardians must give their consent for the process to begin in the first place, they must be notified in advance of district actions regarding their child's special education, and they must be encouraged to participate in developing the IEP.

2.2 Activity: Further Understanding the Rights of Students

Paraeducators will participate in an activity analyzing various scenarios regarding the rights of children.

2.2.1 Steps

- Divide the class into five groups.
- Present the **Scenario** handouts **(H8/H9/H10/H11/H12)**, one to each group.
- Have each group read and discuss whether or not a right was being violated, and, if so, how can the situation be corrected? Distribute the

Rights of Students handout **(H13)** to aid the participants.

- When finished, have the groups share and discuss their scenario with the class.

2.3 Lecture: Rights of Exceptional Students Under Statutory and Case Law

Referring to the scenarios in the previous activity, further discuss the rights of exceptional students under statutory and case law.

Free Appropriate Public Education

- Both Section 504 of the Rehabilitation Act of 1973 and P.L. 94-142 guarantee that every child eligible for special education services will receive a "free appropriate public education." Under Section 504, a recipient of federal financial assistance that operates a public elementary or secondary school must provide a free appropriate public education to each qualified child regardless of the severity of the child's handicap. (29 U.S.C. Section 794.)
- The term ***free appropriate public education (FAPE)*** is specifically defined in the regulations accompanying P.L. 94-142 as:
  - "...Special education and related services which: (A) have been provided at public expense, under public supervision and direction, and without charge; (B) meet the standards of the State educational agency; (C) include an appropriate preschool, elementary, or secondary school education in the State involved; and (D) are provided in conformity with the individualized education program required...(20 U.S.C. Section 1401)"
- The United States Supreme Court has further expanded on this definition:
  - "...If personalized instruction is being provided with sufficient supportive services to permit the child to benefit from the instruction, and the other items of the definition checklist are satisfied, the child is receiving a 'free appropriate public education' as defined by the Act (Board of Education of Hendrick Hudson School District v. Rowley, 458 U.S. 176, 177 (1982))."
  - By ***definitional checklist*** the Court meant that the instruction must: be provided at public expense, meet state standards, approximate the grade levels used in regular education, and comply with the child's individualized education program. In

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addition, the Supreme Court's decision in Rowley clearly recognized the need to address each question involving appropriate programming, that it usually must be resolved on an individual or case-by-case determination.

- In some cases, children may require programming that extends beyond the traditional school year in order to benefit from their educational placement, to make progress and maintain their progress. Other children may need related services, such as transportation, therapy (speech/language, occupational, physical, psychological), recreation, or counseling to assist them in benefiting from the educational process. In addressing the range of services that a child might require in order to benefit from the school program, the U.S. Supreme Court set out three broad limitations in its decision in Irving Independent School District v. Tatro (104 S. Ct. 3371 (1984)):
  - The child must be eligible for special education services.
  - The child must need the services to benefit from his or her education program.
  - The services provided must be the type that can be provided by a qualified person other than a physician. The Court determined that clean intermittent catheterization was a related, not medical, service that had to be provided to the child.
- The requirement that special education be tailored to meet the unique needs of an eligible student has been interpreted by one court to mean that some children may require an education program that extends beyond the standard school year. In Battle v. Commonwealth of Pennsylvania (629 F. 2d 269 (3rd Cir. 1980)), the Third Circuit Court of Appeals ruled that the state's rule limiting the school year to 180 days was invalid where the standard school program failed to meet the unique needs of the child.
- A few children will have needs that are so substantial that their needs cannot be met even by extended-year schooling. For the few children whose needs are so great that they can benefit only from an intensive, full-time program, the only option may be a residential placement. Such a placement is segregated and falls to one extreme on the continuum of educational program options. When a residential placement is indicated, it is important to discern what services make that placement superior and determine if it would be feasible to provide those services in a less restrictive placement.
- Although the question of what constitutes a free appropriate public education turns on the unique needs of each child and the issue of

educational benefit to that specific child, determining these factors can be quite difficult. In situations where disputes have arisen between parents and school districts, the party who was successful has usually been the party whose evidence best demonstrated the child's particular needs. Judges and hearing officers are strongly influenced by testimony and reports from qualified witnesses who have had continuous contact with the child and/or the program in question. Even if a child is advancing from grade to grade in a regular public school, judges do not automatically determine that the child is receiving a free appropriate public education.

- Parents who prevail in a dispute regarding the provision of FAPE may be entitled to obtain compensatory services for their child for the period of time when the needed services were not being provided. In some cases parents have received reimbursement of expenses for private therapy, private placement, or transportation. It is unwise, however, to rely on reimbursement for expenses or the provision of compensatory services when taking unilateral action in placing a child in a segregated private facility, contracting for private therapy, or providing transportation to benefit a child educationally.
- One must keep in mind that the FAPE requirement focuses on adequate and appropriate education. There is no requirement in either the statutes or the case law that a child receive education to his or her fullest potential or that local education agencies confer upon special education students maximum educational benefit from their school programs.

Extended School Year (ESY)

- In the early 1980s, several federal courts addressed state policies limiting special education instruction to the same 180-day instructional period provided to students in regular education. In each case, the policy was struck down by the court as violation of the FAPE provision in P.L. 94-142 because such a broad policy did not allow for consideration of the needs of an individual child. For some students with special needs, the provision of a free appropriate public education means extending instruction and related services beyond the typical 180-day school year. An extended school year (ESY) must be provided to a student who has special needs and is eligible for such programming.
- A review of the court decisions related to ESY suggests that eligibility for extended services related to three criteria:
  - The type and severity of the child's handicapping condition.
  - Evidence of a significant regression/recoupment problem.

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- The effect of the regression/recoupment problem on the child's ability to obtain his or her educational goals.

- Eligibility for ESY in many states, however, has focused almost exclusively on the second criterion, the regression/recoupment aspect. Generally speaking, all students regress or lose some skills over their summer break; however, some children with special needs experience a loss of skills or regression that is so great, it takes the better part of the next school year to regain or recoup those skills.
- Some school districts have further developed the eligibility criteria for ESY and adopted guidelines for determining the amount and kind of ESY services. This expanded criteria might include:
  - Will the educational benefits desired during the regular school year be jeopardized significantly if there is no educational programming during the summer?
  - Has the student lost or been denied services during the regular school year?
  - Could the child benefit from a regular summer school program, modified to meet the student's learning needs?
- The need for ESY should be discussed at the annual IEP review. It is often helpful to add a statement or two to the IEP that baseline data and data concerning regression and recoupment will be collected on the student preceding and following any extended break in his or her academic routine. If ESY was not discussed at the annual review, parents may request a review staffing specifically for the purpose of addressing the student's need for ESY. Such a staffing should be scheduled early enough in the school year to resolve the issue prior to the end of the regular school year. This timing also allows school districts to adequately plan for personnel and facilities to meet the needs of all children in ESY programs.
- It may be preferable to have a separate IEP document to address the child's ESY needs and services. Some districts attach an addendum or separate form describing the ESY program, this is also acceptable. The most important aspect of the ESY staffing is to develop a written program that clearly defines the length, type, and intensity of services that will be offered to the student during the extended school year.
- Documenting the need for ESY often requires considerable thought and preparation. Specific behaviors or skills of primary importance to the child should be selected and charted. Observational data is often subjective, but may be the best method of documenting regression and recoupment. Private therapists may also be a good source of information concerning

how to document the need for ESY. The type of information needed will be as individualized as the student.

- Parents should be aware that the school district's financial problems are not an acceptable legal reason for denying ESY to a student who is eligible for extended school year programming. In addition, parents should be wary of summer programs that are offered because they are already in place (e.g. recreational programs) but do not meet the child's educational needs. Extended year programming, like regular school year programming, must be designed to meet the child's individual needs.

Least Restrictive Environment (LRE)

- One of the provisions of the Education for All Handicapped Children Act (P.L.94-142) is that special education occur in the least restrictive environment. The law requires public agencies to insure that, to the maximum extent appropriate, children with handicapping conditions be educated with children who are not handicapped and that special classes, separate schooling, or other removal of children with handicapping conditions from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.
- Unless the individualized educational program for a child with a handicapping condition requires some other arrangement, the child is educated in the school which he or she would attend if they were a typical student; and in selecting the least restrictive environment, consideration is given to any potentially harmful effect on the child or on the quality of services which he or she needs.
- The Least Restrictive Environment mandate under P.L.94-142 and Section 504 is a powerful one. It encompasses several important concepts that are mentioned in the regulations and described here in greater detail.

Integration, Mainstreaming, and Inclusion

- When developing a special education program for a student with a handicapping condition, consideration must be given to the extent of time the child will spend in regular education programs with peers who are not handicapped. In other words, the IEP that is written for the student must contain a recommendation for the amount of the time the child will be mainstreamed or integrated with students who are not handicapped in a

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regular school setting. This may be expressed in terms of actual hours, classes, or in percentage of the school day or week.

- Integration is a vital component to the education of students with disabilities. Segregated settings may prepare students to function only in segregated settings. The world is not segregated. Only an integrated setting can expose students to the myriad of situations they will encounter during their lives. It is equally important for students who are not handicapped to be exposed to their peers who have handicaps, and to understand and accept a variety of human differences. Even when a particular student's needs are capable of being met only in a specialized school setting, opportunities for integrated activities should be included in the student's educational program. Many of the supports and services traditionally offered in segregated settings are often not only available in integrated settings, but implemented with greater benefit to the students in an integrated setting.
- For parents to be effective advocates for their child they should understand that the law provides that students with disabilities are to be educated to the fullest extent possible with students who are not handicapped. Placement into educational programs should be based on the student's individualized educational program and not simply what is available.

Goal 3: Know the steps and processes of special education services in Colorado.

3.1 Lecture: Referral Process

Present and review the **Special Education Services** and the **Service Delivery for Students Who Qualify for Special Education** handouts and transparencies **(H14/H15/T5/T6)**. Use a copy of your school district's IEP to facilitate this lecture, point out where parts of the flowcharts mesh with the components of the IEP.

3.2 Lecture: Special Education Process

2220-R-4.00 Special Education Process

Child Identification Process

- 4.01 Child Identification Process
  - Each administrative unit shall have a procedure for locating, identifying, and evaluating all children ages birth to 21 who may have a disability and be eligible for special education services. These procedures shall be available to all children including children who have not yet entered school, children who discontinue their education, children who are placed in private schools, or children who choose home schooling and may be suspected of having a disability.
  - 4.01 (1) The child identification process in each administrative unit shall:
    - 4.01 (1) (a) Be a process designed to inform the public and to actively seek out and identify children ages birth to 21 who may be eligible to receive special education services, or in the case of infants and toddlers early intervention services.
    - 4.01 (1) (b) Be designed to utilize available resources within the community.
    - 4.01 (1) (c) Involve families and provide information to the families.
  - 4.01 (2) Each administrative unit shall have one person designated as the child-find coordinator who shall be responsible for an ongoing child identification process.
  - 4.01 (3) The child identification process shall include specific

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strategies for children from birth through five years of age, children in school, and children out of school who are discontinuers or dropouts. It shall be available throughout the year and shall include the following components:

- 4.01 (3) (a) Planning and development in the areas of public awareness, community referral systems, community and building based screening, diagnostic evaluations, service coordination, and staff development.
- 4.01 (3) (b) Coordination and implementation in the areas of interagency collaboration, public awareness, referral, screening, and resource coordination.
- 4.01 (3) (c) Screening procedures for identifying from the total population of children ages birth to 21 years those who may need more in-depth evaluation in order to determine eligibility for special education and related services, or in the case of infants and toddlers early intervention services.
  - 4.01 (3) (c) (i) Follow up to vision and hearing screening shall interface with the vision and hearing screenings which occur for all children in public preschool, kindergarten, and grades 1, 2, 3, 5, 7, and 9 yearly in accordance with C.R.S. 22-1-116. Appropriate educational or early intervention referrals shall be made if the child is suspected of having an educationally significant vision or hearing loss and parents shall be informed of any need for further medical evaluation.
  - 4.01 (3) (c) (ii) A systematic procedure for considering those children ages 16 to 21 who are out of school and who may have a disability.

- Referral procedures should ensure that parents of children are given information about all public and private resources that can meet identified needs. This may include a process for either a building level or early intervention referral. The building level process is to consider all pertinent information, the unique needs of the child, and to generate alternative strategies for meeting these needs in non-special education settings or to determine the need for special education referral. These procedures may include dropout prevention strategies and recruitment of special education.
- Should a child attend school in an administrative unit other than where the child resides, the responsibility for child identification up through special education referral lies with the administrative unit of attendance. The unit of

attendance must notify both the parents and the administrative unit of residence of the special education referral.

- Should the child reside and attend school in an administrative unit other than where the parents reside, the responsibility for child identification, assessment and determination of a disability lies with the administrative unit of attendance.
  - 4.01 (5) (a) If the disabled child's unit of residence would be different from the unit of attendance, the administrative unit of attendance shall notify the administrative unit in which the child's parent resides prior to the assessment process so that the administrative unit of residence can choose whether or not to participate in the assessment and determination of disability.
  - 4.01 (5) (b) If the administrative unit of residence disagrees with the determination of disability, the unit may elect to initiate an informal process such as negotiation or mediation or it may request the Commissioner of Education to make a determination of the district of residency.
  - 4.01 (5) (c) If the determination is made that the child has a disability, an individualized educational program (IEP) shall be developed by the administrative unit of residence according to Section 4.04 of these Rules.

Special Education Referral Process

- Referral procedures are used to ensure that parents of children are given information about all public and private resources that can meet identified needs. This may include a process for either a building level or early intervention referral. The building level process is to consider all pertinent information, the unique needs of the child, and to generate alternative strategies for meeting these needs in non-special education settings or to determine the need for special education referral. These procedures may include dropout prevention strategies and recruitment of special education discontinuers.
- 4.02 Special Education Referral Process
  - A special education referral shall be clearly distinguished from a building level referral or a referral for screening, both of which are regular education processes. The administrative unit shall establish and follow procedures for referring a child for assessment and to determine whether or not the child has a disability. The referral process shall be accessible to any person, organization or agency having an interest in the

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education of the child.

- 4.02 (1) A special education referral may be initiated:
  - 4.02 (1) (a) As a result of a building level screening and/or referral process.
  - 4.02 (1) (b) Directly by a parent or other interested person.
- 4.02 (2) A parent of any child referred shall be informed of the referral and of all procedural safeguards relevant to children potentially eligible for special education, including procedures for resolving differences.
- 4.02 (3) Once a written special education referral has been initiated, assessment, planning, determination of disability, and, if disabled, IEP development shall be completed within 45 school days from the point of initiation of the special education referral. The special education referral process is initiated when one of the following occurs:
  - 4.02 (3) (a) The parent is informed of the special education referral as a result of the building level process or screening and permission to assess is obtained.
  - 4.02 (3) (b) The request for special education referral is received from the parent or other interested person as a direct referral.
- 4.02 (4) A record shall be maintained of the disposition of each special education referral.

Assessment Process

- An assessment process for children ages 3 to 21 shall be provided for the purposes of evaluation for eligibility and for planning. The evaluation process shall include an assessment by a person with expertise in the child's suspected area of disability. In addition, personnel representing various disciplines shall conduct assessment in all areas outlined in Section 4.03 (9). In the case of infants and toddlers an assessment shall be conducted in conjunction with the local interagency effort and an appropriate individualized plan developed.
  - 4.03 (1) The assessment process shall include a review of all pertinent information provided by the referring party or already available to the administrative unit.
  - 4.03 (2) Prior to the assessment process the parent(s) of any child referred shall be notified in writing of:

- 4.03 (2) (a) The types and reasons for any assessments which may be conducted, with the opportunity for a face-to-face conference prior to the assessment with administrative unit personnel in a language utilized by the parent.
- 4.03 (2) (b) Their procedural safeguards as described in the Code of Federal Regulations 300.505.

➥ 4.03 (3) Prior to the initial assessment for placement into special education services, administrative unit personnel shall give written notice to parent(s) and obtain written permission from parent(s) to conduct the assessment. Prior to any subsequent assessments for eligibility purposes parent(s) shall be given written notification.

- If parent(s) refuse to give permission for the entire initial assessment or any part of the initial assessment required in Section 4.03 of these rules or fails to respond after reasonable efforts by the administrative unit, and the local school board believes that the assessment is in the child's best interest, the local school board may elect to initiate informal processes, such as negotiation or mediation, or may initiate due process proceedings or court proceedings to obtain authorization for assessment.
- If the child's parent(s) is unknown, cannot be located, or is otherwise unavailable, the administrative unit shall appoint an educational surrogate parent prior to proceeding with any assessment.

➥ 4.03 (4) Assessment procedures shall protect the interests of the child.

- Administrative unit personnel evaluating children for the purpose of determining eligibility for special education services shall be appropriately certificated or endorsed. For those areas in which certification or endorsement is not available, appropriate licensure or registration is required.
- The evaluation instruments used for assessment of a child shall be selected to minimize cultural, gender, or ethnic bias.
- Children shall be evaluated in their primary language and/or through the use of nonverbal techniques. Children who cannot read, write, speak, or understand the English language as determined through appropriate testing may not be determined eligible for special education services on the basis of criteria developed solely upon the command of the

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English language.

- ⇉ Evaluation instruments shall be valid and reliable.

- ➥ 4.03 (5) Each administrative unit shall develop procedures that describe the general nature of the assessment procedures to be followed by its staff, including the selection of instruments.
- ➥ 4.03 (6) Assessment procedures used for the determination of eligibility shall have been completed no more than 12 months prior to the meeting at which eligibility is determined.
  - ⇉ Appropriately certificated, endorsed, registered, or licensed personnel shall complete assessment procedures appropriate to the suspected area of disability in sufficient scope and intensity to determine whether the child meets the criteria for eligibility and to identify the nature of the child's special education needs. When the assessment planning team determines, on an individual basis, that a specific formal assessment procedure is not appropriate an informal assessment may replace a formal assessment procedure.
- ➥ 4.03 (8) The assessment shall include formal and informal measures.
  - ⇉ 4.03 (8) (a) Formal measures are individually administered standardized test instruments and/or normative data. Formal evaluations conducted by the administrative unit shall be administered by individuals appropriately licensed / certificated and endorsed in the areas being assessed. For those disciplines in which licensure/certification and/or endorsement is not available, other appropriate licensure or registration is required. In order to be considered by the planning committee, formal independent or private evaluations shall be conducted by appropriately licensed/ certificated and endorsed, or other appropriately registered or licensed personnel. Upon written request from the administrative unit, the parents of the child shall have the responsibility to secure information regarding the credentials of the individual(s) completing the independent or private evaluation. This request shall provide the state's criteria for licensure/certification and endorsement, or other licensure or registration.
  - ⇉ 4.03 (8) (b) Informal measures include but are not limited to observation, anecdotal records, behavior sampling, review of records, interviews, and checklists.
- ➥ 4.03 (9) An assessment shall be completed and documented in the

following areas prior to the meeting at which a disability is determined. Persons may contribute assessment information in more than one of the following areas:

- 4.03 (9) (a) Cognitive (intellectual and perceptual functioning).
  - Assessment of cognitive functioning shall include the psychological processes involved in intelligence and perception.
- 4.03 (9) (b) Social/emotional functioning (including adaptive behavior).
  - Assessment of social/emotional functioning shall include a sampling of behaviors in the home, school, and community using one or more of the following: standardized measures, observation, behavior counts, interview(s), performance samples, checklists, projective techniques, and record reviews.
- 4.03 (9) (c) Physical functioning.
  - Assessment of physical functioning shall include a health history, current health status, observations of the child, and screening of vision and hearing acuity. Assessment of motor functioning may also be included. If vision or hearing screening is failed, formal assessment of vision or hearing shall be completed. A variety of procedures and processes may be used to obtain a health history and current health status.
- 4.03 (9) (d) Communicative (speech and language) functioning.
  - Assessment of communicative functioning shall include one or more of the following: language samples, observations, checklists, interview(s), performance sampling, record review, and/or standardized tests and may occur in a variety of environments.
- 4.03 (9) (e) Educational achievement.
  - Assessment of educational performance shall include standard measures or other appropriate means devised by the examiner. For some children, developmental and/or functional assessment may

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substitute for educational assessments.

- 4.03 (9) (f) Life skills/career/transitional performance.
  - Assessment of functional life skills and vocational skills shall include one or more of the following: standardized measures, observation, behavior counts, interview(s), performance samples, interest inventories, skill analysis, checklists, and record reviews and may occur in a variety of environments including home, school, and community.
  - Information for younger children may be more appropriately obtained by developmental and/or environmental assessment techniques and/or through utilization of nationally or professionally recognized instruments.
- 4.03 (10) Re-evaluation.
  - 4.03 (10) (a) The reevaluations must be conducted as follows:
    - 4.03(10)(a)(i) Comprehensive evaluations must be completed in accordance with Section 4.03(9) of these Rules: every three years, prior to change of disability and eligibility, and prior to termination from special education.
    - 4.03(10)(a)(ii) Evaluations must be completed in appropriate areas identified in Section 4.03(9) of these Rules prior to a significant change in placement.
    - 4.03(10)(a)(iii) Evaluations may be conducted more frequently if conditions unique to the child warrant.
  - 4.04 (10) (b) Prior to the reevaluation, the parent(s) shall be notified in writing based on procedures of 4.03 (2) of these Rules.

3.3 Lecture: Basic Human Rights

Present and briefly review the **Basic Human Rights** handout and transparency **(H16/T7)**.

We all have the right to:

- Act in ways that promote our dignity and respect as long as the rights of others are not violated in the process.

- Be treated with respect.
- Experience and express our feelings.
- Ask for what we need.
- Make mistakes and take responsibility for them.
- Ask for more information or help.
- Assert ourselves or choose not to.

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Goal 4: Articulate the values and rationale for inclusion of students with disabilities into general education.

4.1 Lecture: Inclusion

Inclusive education is a philosophical and programmatic orientation toward placement in the least restrictive environment regardless of the student's categorical label. It promotes a normalized educational experience for students and their families. An important part of inclusion is the extensive cooperation and collaboration between general education and special education teachers and administrators.

Students attend their neighborhood or "home" school.

Individualized special education programs are referenced to the general education curriculum and primarily take place in general education classrooms.

School resources and areas of the school are used by students with disabilities in the manner and at times such resources are used by other students.

Structured and unstructured ongoing interaction between students with or without disabilities occurs.

The community-based instruction needed to prepare students to function in integrated adult environments is provided.

4.2 Discussion: Knowledge Assessment

Using the **Knowledge Assessment** transparency **(T2)**, engage the participants in a discussion reviewing the ideas presented in this module. Ask the group to provide answers to each question, making notes on the transparency. Discuss, clarify and review where needed.

Module A Handouts

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Module A: History, Legal Precedents, and Values

1. Know major laws and court rulings that have helped shape special education services.

2. Know the legal rights of students with disabilities and the qualification processes for special education services and 504 plans.

3. Know the steps and processes of special education services in Colorado.

4. Articulate the values and rationale for inclusion of students with disabilities into general education.

Knowledge Assessment

- What was the intent of P.L. 94-142?

- P.L. 94-142 was replaced by the Individuals With Disabilities Education Act (IDEA). IDEA was reauthorized and signed into law in June of 1997. List three of the major changes that you are aware of that exist between P.L. 94-142 and IDEA.

- What does ***least restrictive environment*** mean?

- What is an IEP?

- What is meant by the term ***inclusion***?

- What did special education look like in early civilizations?

- What are the legal rights of students with disabilities?

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Historical Perspective

- Early History
- Era of Institutions
- Era of Public Schools
- Era of Accelerated Growth
- Major Legislation

History of American Schools

America's public schools can be traced back to the year 1640. The Massachusetts puritans who created these first schools assumed that families and churches bore the major responsibilities for raising a child. The responsibility of the school was intended to be limited, primarily focused on:

- Teaching basic reading, writing and arithmetic skills,
- Cultivating values that serve a democratic society (some history and civics implied).

America's schools stayed focused for 260 years.

At the beginning of this century, society began to assign additional responsibilities to the schools. Politicians, business leaders, and policy makers began to see the schools as a logical site for the assimilation of newly arrived immigrants and the perfect place for the social engineering of the first generation of the "Industrial Age." The practice of increasing the responsibilities of the nation's schools began then and has accelerated ever since.

From 1900 to 1920 we added:

- Nutrition,
- Immunization, and
- Health.

From 1920 to 1950 we added:

- Vocational education
- The practical arts,
- Physical education, and
- The school lunch program (We take this for granted today. It was, however, a significant step to shift to the schools the opportunity to provide lunches instead of all children bringing lunches from home.).

In the 1950s we added:

- Safety education,
- Driver's education,
- Foreign language requirements are strengthened, and
- Sex education introduced (topics escalate through the 90s).

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History of American Schools

(continued)

In the 1960s we added:

- Consumer education,
- Career education,
- Peace education,
- Leisure education, and
- Recreational education.

The 1970s see greater educational legislation:

- Special education is mandated by federal government,
- We add drug and alcohol abuse education,
- Parent education,
- Character education, and
- School breakfast programs appear.

In the 1980s the floodgates open and we added:

- Keyboarding and computer education,
- Global education,
- Ethnic education,
- Multicultural/non-sexist education,
- English as a Second Language and bilingual education,
- Early childhood education,
- Full day kindergarten,
- Preschool programs for children at risk,
- After school programs for children with working parents,
- Stranger/danger education,
- Sexual abuse prevention education, and
- Child abuse monitoring becomes a legal requirement for all teachers.

And finally, so far in the 1990s we have added:

- HIV/AIDS education,
- Death and dying education,
- Gang education,
- Bus safety, and
- Bicycle safety education.

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I. Education Rights Generally

Introduction

Joe is a twelve-year-old boy who has been blind since birth. He also has a congenital hearing impairment and uses a special hearing aid. He attends middle school and likes many of the board games that sixth graders like to play. Although Joe has some difficulty with reading, he's doing above grade level math.

Debra is seventeen and uses a wheelchair to get around the halls of her high school. She sustained a spinal cord injury in an automobile accident when she was fifteen. Debra participates in many extracurricular activities and plans to go to college and become a veterinarian.

Six-year-old Jessica is a pretty girl with long dark hair and big blue eyes. It is difficult to tell that Jessica has such pretty eyes, however, as she rarely looks at people when they talk to her and she does not respond verbally when she communicates with others. Jessica experiences very little contact with her external environment and has to be reminded to look at others or at the object that she is working on.

Each of these children has a handicapping condition that only a decade or so ago would have prevented them from attending public schools. Although education programs for children with special needs have been in existence in some states since the turn of the century, those programs were very different from the special education programs of the 1980's, following passage of the Education for All Handicapped Children Act (PL 94-142) in 1975.

Early special education programs generally served only children with mild disabilities in separate schools and for a much shorter school day and year. Encouraged by the Civil Rights movement of the 1960's, parents and advocates turned to the courts for support in establishing educational rights for children with disabilities.

Early Case Law

The door to educational rights was opened by one court in Pennsylvania Association for Retarded Citizens (PARC) v. Pennsylvania, 343 F. Supp. 279 (E.D. Pa 1972). In that case, parents challenged four Pennsylvania laws that excluded children with mental retardation from a public school education. The district court ruled that all Pennsylvania children with mental retardation, regardless of the nature or severity, were entitled to an appropriate public education. The federal

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court of the District of Columbia opened the door even wider when it ruled in Mills v. Board of Education of the District of Columbia, 348 F. Supp. 866 (D.D.C. 1972) that a free, appropriate public education had to be provided to every school-aged child in the district regardless of the degree of the child's mental, physical, or emotional impairment.

Both of these courts relied upon the 1954 United States Supreme Court decision in Brown v. Board of Education, 347 US. 483, 74 S. Ct. 686 (1954), which states that education must be provided equally to all students and that separate educational facilities did not meet the requirement of being equal. Although the Brown case arose as the result of racial segregation in schools, the courts since Brown have successfully applied the premise that separate is not equal to support integration of students with disabilities in regular public schools.

Applicable Federal Law

PL 94-142

As a result of the civil rights movement, the initial court cases, advocacy by parents and various support groups, and the establishment of a federal focus in the Bureau of the Education for the Handicapped, Congress passed some of the most significant legislation ever in the form of the Education for All Handicapped Children Act (Public Law 94-142). This federal law provided educational funds to states that complied with the various portions of the law and standardized access to education for all children with handicapping conditions.

More important, perhaps, than the right itself, PL 94 142 provided for a means to enforce the right to education through specifically described parental rights. These are discussed in greater detail later in the section on Enforcing Your Child's Rights. The parental rights described in this handbook apply to legal guardians and designated surrogate parents as well.

Section 504

In addition to PL 94-142, Congress enacted the Rehabilitation Act of 1973, which contains other safeguards to protect the rights of all persons with disabilities from discrimination. Section 504 of the Act specifically prohibits recipients of federal funds from discrimination based on handicapping condition. Public schools must comply with this law because all are recipients of some federal funding.

Generally speaking, schools comply with the law by guaranteeing equal access and equal

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opportunities to all children regardless of handicapping condition. For example, if a school district provides a summer school program, it must allow students with disabilities to enroll in the program as well as non-handicapped students.

FERPA

Another federal law that is sometimes called upon to protect the rights of parents with children in special education programs is the Family Education Rights and Privacy Act (FERPA), also known as the Buckley Amendment. The three most important provisions of this Act are: (1) access by parents to all education records directly related to the student; (2) the right to an administrative hearing to challenge "inaccurate, misleading, or otherwise inappropriate" data in the education records; and (3) limitations on the school's disclosure of information in the education records to third parties without parent consent.

While FERPA does not cover all institutions receiving federal funding, it does apply to all educational agencies or institutions to which federal funds are made available under any federal program for which the US Commissioner of Education has administrative responsibility. Therefore all public schools are subject to the Act. Parental rights under this law are discussed later in the section of Access to Records and Confidentiality.

PL 99-457

Public Law 99-457, the Education of the Handicapped Amendments of 1986, contains provisions for services to special needs children from birth through age 5. The new law contains financial incentives for serving children aged 3-5 (preschool) who are not currently receiving services. In addition, the legislation authorizes a voluntary program to address the special needs of infants and toddlers (birth through age 2) and their families.

By 1991, each state, if it wants to continue receiving financial assistance under the two programs described above, must have in place a policy for providing early intervention services to all handicapped infants and toddlers in the state. As of this writing, regulations for implementing the programs and developing policies for provision of early intervention services are still in the draft and revision stages. As soon as the implementing regulations are finalized and adopted, a supplement to this handbook, describing those regulations and parents' rights, will be written.

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Applicable State Law

ECEA

Colorado enacted the "Exceptional Children's Educational Act" (ECEA) prior to PL 94-142 to meet the educational needs of children who are eligible for special education services, and later developed implementing regulations which comply with the requirements imposed upon states by PL 94-142, discussed previously. Children are served under the ECEA if they are between the ages of 5 and 21 and are "unable to receive reasonable benefit from ordinary* education in the public schools because of specific handicapping conditions (Reg. 1.01)." Students must turn 5 before the cut-off date for the local school district and can be served through the school year that they turn 21.

*This means education that does not include supplemental aids or services, i.e., special education services.

Under Colorado's ECEA, children are eligible for services if they have one or more of the following handicapping conditions:

1. Physical condition, impairment or sustained illness.
2. Vision impairment.
3. Hearing impairment.
4. Significant limited intellectual capacity (SLIC).
5. Significant identifiable emotional or behavioral disorder (SIEBD).
6. Perceptual or communicative disorder (specific learning disability) (PC).
7. Speech impairment.
8. Multiple handicap (two or more of the above when severe enough to interfere with ability to function and learn).

Local education agencies are mandated to make reasonable efforts to seek out and identify all children between the ages of birth and 21 who may be in need of special education and related services or programs and children 5-21 are currently eligible for these programs or services. Furthermore, the ECEA requires local educational agencies to establish referral and assessment procedures for children who are identified as needing special education. (Regulations 3.00 - 3.03)

Specific provisions of the ECEA are discussed in other sections of this handbook where they relate directly to the rights afforded parents or the basic concepts described in the federal laws. In some cases, the ECEA and its accompanying regulations expand parental rights and school district

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responsibilities beyond those outlined in the federal laws and regulations.

Alternative Placements to Meet LRE Requirements. Section 300.552 of the regulations, quoted at the beginning of this section, includes the factors which must be considered when determining what the least restrictive placement is for a particular child. The overriding rule is that placement decisions must be made on an individual basis, based on the unique needs of each particular child. The full school program—academic and nonacademic—should be targeted for integration.

Integration or mainstreaming is the maximizing of opportunities for children with handicapping conditions to associate with other students and adults without disabilities in normal, natural ways. It is a broad concept that can be carried out in the community as well as in school.

Eating lunch in the cafeteria, riding a school bus, going to a regular science class, participating in regular art, music, and P.E. classes, "hanging out" in the halls and attending school pep rallies are examples of ways students with disabilities can integrate with other students in a school setting.

Community integration may be a component of some students' special education programs. For those students, integration may mean performing a job with employees who do not have a disability, riding public transportation to the community recreation center, and shopping in the neighborhood market.

Consideration should be given to where and how the child will live, work and recreate as an adult. The educational program and placement should reflect these considerations. The focus should always be on the child's abilities and potential rather than on his or her limitations. When parents advocate for the least restrictive setting the school has the responsibility to prove that a restriction is necessary.

Appropriate Placements

The broad concept of LRE also includes the requirement that placement be based on the student's individual needs. Several courts have dealt with the issue of individualized placement and the rulings support the notion that automatic placements based solely on a child's classification (deaf, mentally handicapped, etc.) are in violation of federal laws.

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The child in the leading LRE case, Roncker v. Walter (700 F.2d 1058 (6th Cir. 1983) (Cert. denied 464 US. 864(1983)), had a handicapping condition of mental retardation. The school district placed the child in a segregated facility. The parents appealed the placement on the grounds that the district violated the requirement of P.L 94-142 to educate their child with non-handicapped children to the maximum extent appropriate, i.e., in the least restrictive environment (LRE).

The court in Roncker v. Walter stated that the test for meeting the LRE requirement meant asking whether the child's "educational, physical or emotional needs require some service which could not feasibly be provided in a class for handicapped children within a regular school..." (700 F. 2d 1058,1063). In addition, the court listed several unacceptable reasons for schools to place children in segregated programs:

1. Related services are more easily provided in a separate setting.
2. Special equipment is available in a separate facility.
3. Better qualified teachers and support staff are available in a separate facility.
4. A particular program or curriculum is only offered in a separate facility.
5. More intensive services are available in a separate facility because of smaller teacher-pupil ratio.

Special Education Language Key

ADD Attention Deficit Disorder

ADHD Attention Deficit Hyperactivity Disorder

ADPE Adaptive Physical Education

AR Annual Review

EMH Educable Mentally Handicapped (SLIC)

ESY Extended School Year

FAPE Free Appropriate Public Education

FERPA Family Education Rights and Privacy Act

HH Hearing Handicapped

IDEA Individuals with Disabilites Education Act

IEP Individual Educational Plan

IPAT Inclusive Practice Assistance Team

LRE Least Restrictive Environment

MH Multiple Handicapped

OT Occupational Therapist (or Therapy)

P/C Perceptual Communicative

PH Physically Handicapped

PT Physical Therapist (or Therapy)

SEAC Special Education Advisory Council

SIED Significant Identifiable Emotional Disorder

SIED A-Team SIED Assistance Team

SLIC Significant Limited Intellectual Capacity

SLP Speech Language Pathologist

SMN Severe Multiple Needs (currently Life Skills I)

SPED Special Education

S/P Severe/Profound (currently Life Skills II)

SST Student Support Team

TMH Trainable Mentally Handicapped (SLIC)

VH Visually Handicapped

Under Colorado's ECEA, children are eligible for services if they have one or more of the following handicapping conditions:

- Physical condition, impairment, or sustained illness (includes autism and traumatic brain injury).
- Speech impairment.
- Vision impairment.
- Hearing impairments.
- Significant limited intellectual capacity.
- Significant identifiable emotional disorder.
- Perceptual or communicative disorder (specific learning disability).

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Six Major Principles of Student Rights

1. Zero Reject

2. Testing, Evaluation, and Placement

3. Individualized and Appropriate Education

4. Least Restrictive Placement

5. Procedural Due Process

6. Parent Participation and Shared Decision Making

Scenario 1

Jason is five years old. He and his parents moved to a different neighborhood in the same school district. At a transfer meeting, Jason's parents were told that a paraeducator, who worked at their old school but lived in this neighborhood, had done them a favor by bringing over Jason's special education records the previous day.

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Scenario 2

Marshall is sixteen. The paraeducator in his room, Mrs. Jones, always accompanies him to the bathroom because he is a "trouble maker" in the halls.

Scenario 3

Ross, a paraeducator, sat in the coffee room of the school and described his favorite student, Karen, to his best friend, Ann, who worked down the hall in another classroom. Ross talked about all of the mistakes Karen had made over the past two days.

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Scenario 4

Jose is in the first grade. Because he receives low grades, the paraeducator in the classroom tutors him in his most difficult subjects. Everything in the classroom is done in English, but Spanish is the language Jose has grown up with and is what he speaks at home.

Scenario 5

Mary is fifteen and just moved to a new high school. On her first day, one of the paraeducators helped her find her new classes. But, the art room was on the second floor and Mary was unable to get to it in her wheelchair.

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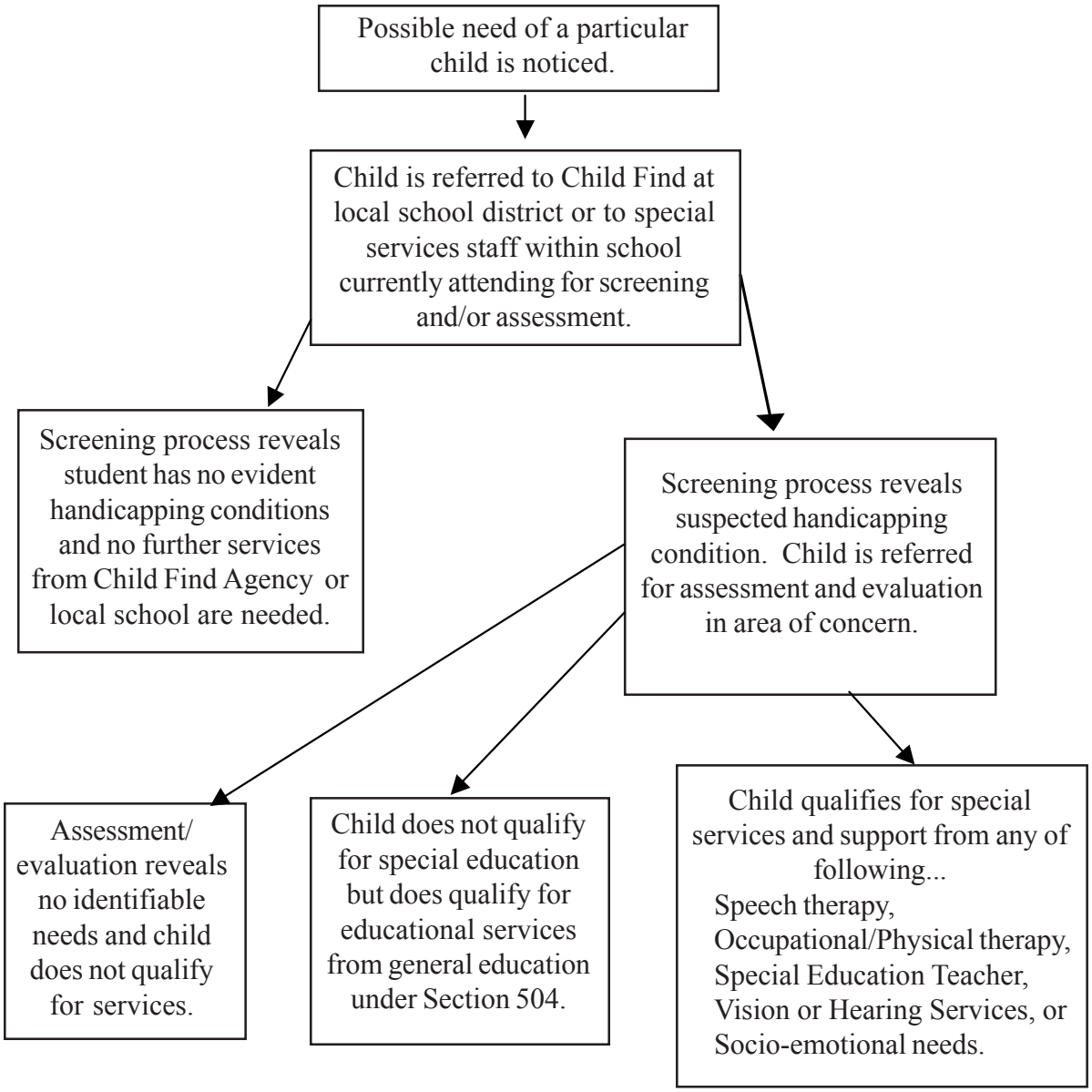
Rights of Students

- IDEA, 1997
- Staffing
- Least Restrictive Environment
- Appropriate Placements
- FERPA/Confidentiality
- Inclusion
- Informal Resolution
- Related Services
- Goals
- Due Process
- IEP Conference
- Individualized Education Program (IEP)
- Free Appropriate Public Education (FAPE)
- Educational Needs
- Extended School Year (ESY)

Special Education Services

Flow of possible services for children prior to appropriate age for attendance at a public school, older than age five but not attending a public school (have discontinued their education, have been placed in private schools or are receiving home schooling) and for children currently attending public schools.



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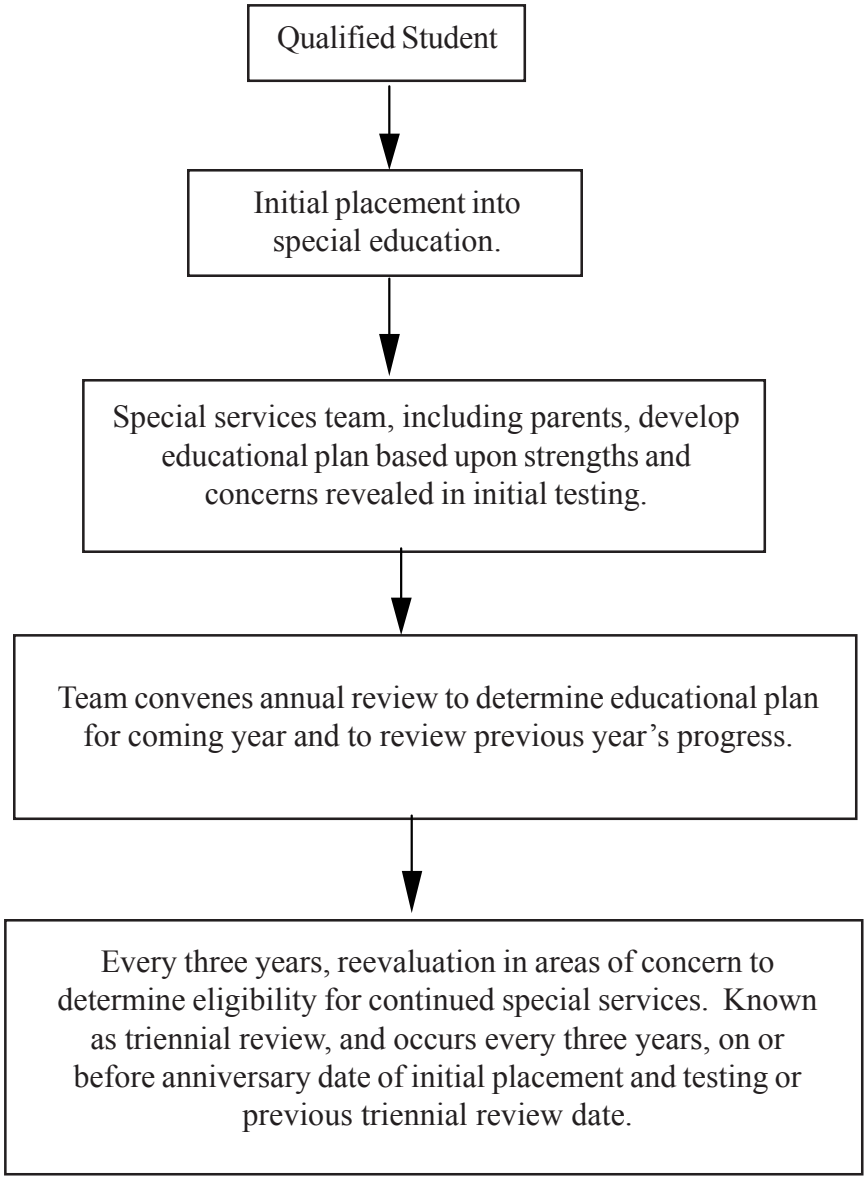
Service Delivery for Students Who Qualify for Special Education



Basic Human Rights

We all have the right to:

- Act in ways that promote our dignity and respect as long as the rights of others are not violated in the process.
- Be treated with respect.
- Experience and express our feelings.
- Ask for what we need.
- Make mistakes and take responsibility for them.
- Ask for more information or help.
- Assert ourselves or choose not to.

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Module A Transparencies

Module A: History, Legal Precedents, and Values

OrSpedA-T1

- ***Know major laws and court rulings that have helped shape special education services.***

- ***Know the legal rights of students with disabilities and the qualification processes for special education services and 504 plans.***

- ***Know the steps and processes of special education services in Colorado.***

- ***Articulate the values and rationale for inclusion of students with disabilities into general education.***

Knowledge Assessment

- ***The intent of P.L. 94-142 is...***
- ***Three major changes from P.L. 94-142 and the Individuals with Disabilities Education Act or IDEA are...***
- ***The "least restrictive environment" means...***
- ***An IEP is...***
- ***Inclusion is...***
- ***What did special education look like in early civilizations?***
- ***What are the legal rights of students with disabilities?***

Historical Perspective

- ***Early History***
- ***Era of Institutions***
- ***Era of Public Schools***
- ***Era of Accelerated Growth***
- ***Major Legislation***

Six Major Principles of Students Rights

1. ***Zero Reject***

2. ***Testing, Evaluation, and Placement***

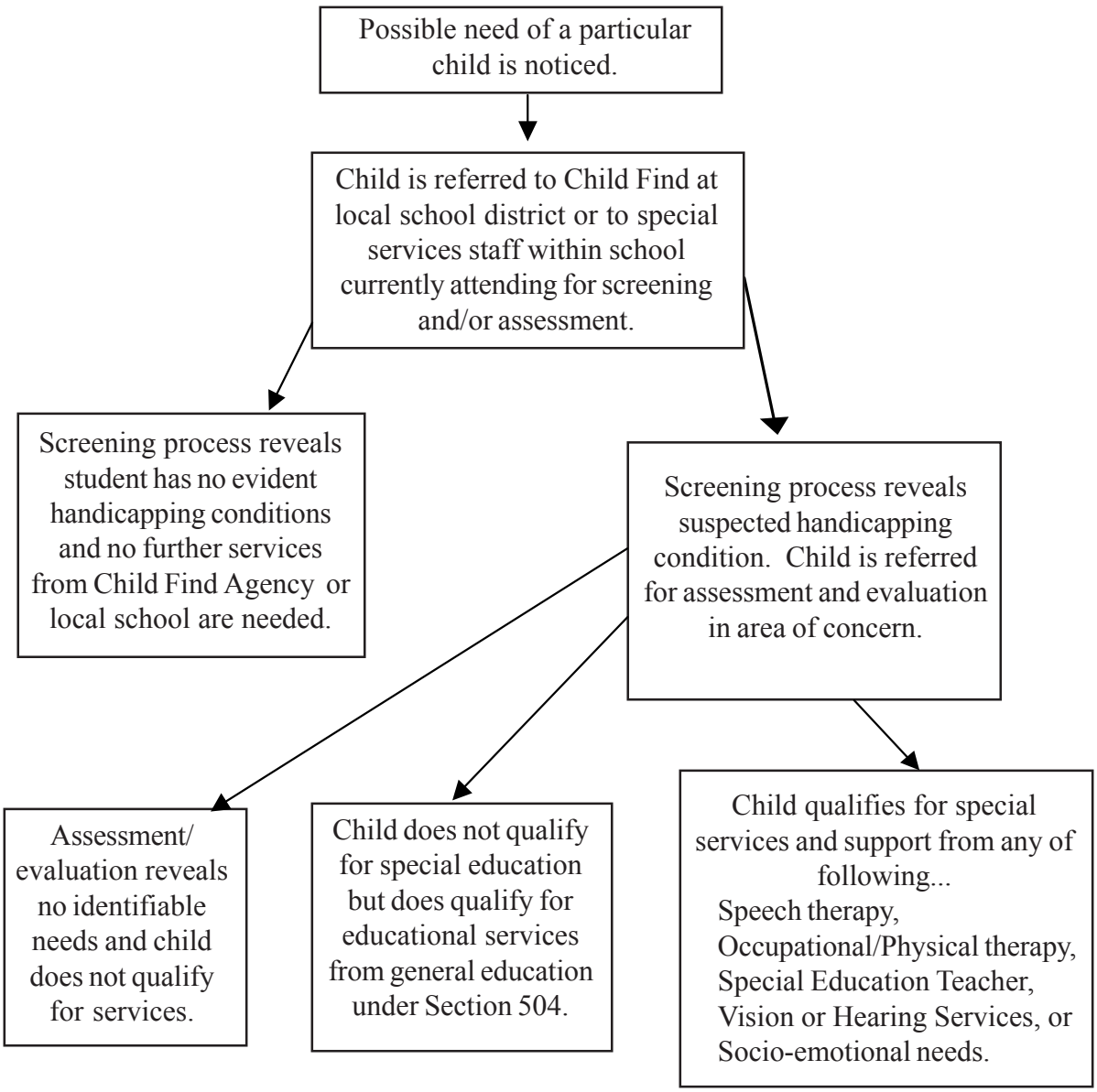
3. ***Individualized and Appropriate Education***

4. ***Least Restrictive Placement***

5. ***Procedural Due Process***

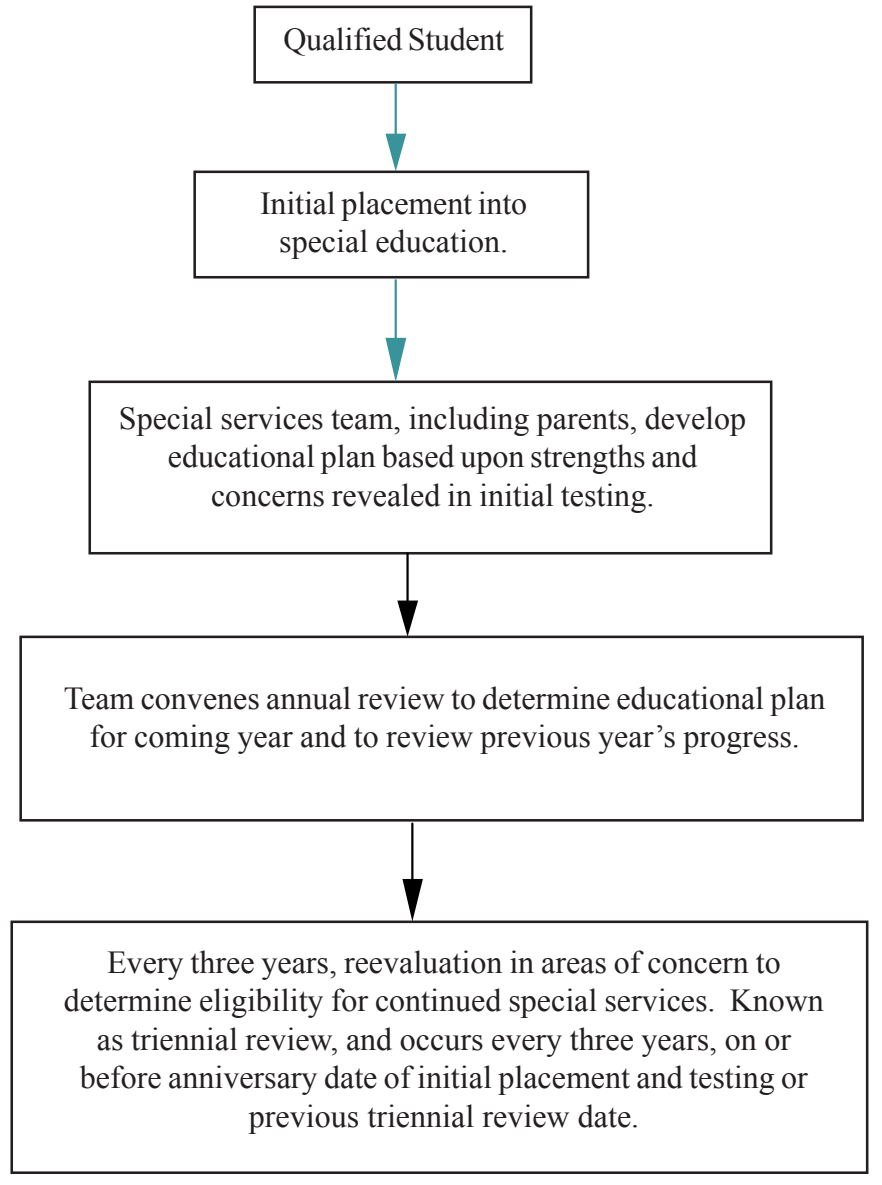
6. ***Parent Participation and Shared Decision Making***

Special Education Services



Service Delivery for Students Who Qualify for Special Education

OrSpedA-T6



Basic Human Rights

We All Have the Right To...

- ***Act in ways that promote our dignity and respect as long as the rights of others are not violated in the process.***
- ***Be treated with respect.***
- ***Experience and express our feelings.***
- ***Ask for what we need.***
- ***Make mistakes and take responsibility for them.***
- ***Ask for more information or help.***
- ***Assert ourselves or choose not to.***

Module B: Overview of Human Growth, Development, and Learning

Orientation to Special Education
Module B: Overview of Human Growth, Development, and Learning

A. Module Goals

Using the **Module B: Overview of Human Growth, Development, and Learning** handout and transparency **(H1/T1)**, review the goals of the module.

1. Identify major cognitive, affective, physical, and communicative milestones of typically developing children and youth.
2. Know basic styles of human learning.
3. Know the risk factors that may prohibit or impede typical development.

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Goal 1: Identify major cognitive, affective, physical, and communicative milestones of typically developing children and youth.

1.1 Lecture: How Do Children Develop?

Present and review the **How Do Children Develop?** transparency **(T2)**.

Development is more than a cumulative list of changes and milestones. It is the cumulation of a personalty and a whole being. There are many principles or milestones that are recognized in typical development, many of which will be reviewed in this module.

Development is predictable. That is how we recognize atypical development. Developmental milestones are attained at about the same age in most children. Environments that provide limited opportunities to children may result in the limited development of some children. Children progress through predictable developmental phases and stages as they grow and mature. Individuals vary and may differ greatly.

1.2 Discussion: Milestones of Development

Present the **Stages of Cognitive Development** handout and transparency **(H2/T3)**. Cognitive development is the process of gaining knowledge and information as the person interacts with their surroundings. Cognitive development depends on growth inside the person, as well as the influence of the outside environment. Review each of the stages of cognitive development with the class. Ask the participants to provide examples of typical behaviors seen in children that would further define and illustrate each stage.

Present the **Stages of Physical Development** handout and transparency **(H3/T4)**. Physical development may be described as the acquisition of motor skills and learning to physically control one's own body. It is characterized by changes seen in the external body and by unseen internal changes in the muscles, bones, and nervous system. Review each of the stages of physical development with the class. Ask the participants to provide examples of various stages of physical development as seen in some students with handicapping conditions. Engage the participants in a discussion about whether or not stages of physical development and chronological age coincide with those stages and ages of cognitive development.

Present the **Stages of Affective Development** handout and transparency **(H4/T5)**.

Affective (or social) development is the process in which a person acquires feelings about him/herself and other people; and acquires the beliefs, skills, values, and behavior patterns necessary for interacting with others. Review the stages of affective development with the class. Ask the participants to provide typical examples of behavior that further illustrate the stages in this developmental process.

Present the **Stages of Communication Development** handout and transparency **(H5/T6)**. Communication development is the process by which a person learns to interact with the environment using speech or some other symbolic system. Ask the participants to provide examples of real communication and specific language that would further describe each of the stages in this developmental process.

1.3 Activity: Child Development Review

Paraeducators will participate in an activity that examines various stages of development.

1.3.1 Steps

- Divide the participants into small groups.
- Present the **Child Development Review** handout and transparency **(H6/T7)**.
- Ask each group to read and discuss the scenarios and identify for each the developmental area and the approximate age and stage being referred to.
- Ask the groups to share and discuss their responses with the class. They should also share how they came about their decisions.

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Goal 2: Know basic styles of human learning.

2.1 Activity: Learning Styles

Paraeducators will participate in an activity examining their own learning styles.

2.1.1 Steps

- Distribute the **C.I.T.E. Learning Styles Inventory** handout **(H7)**.
- Have the participants complete and score the inventory.
- Review the scoring procedures.
  - Circle a score for each inventory item, with "1" being a characteristic that is least like the individual and "4" being a characteristic that is most like the individual.
  - Record the score for each item beside the corresponding number in the last section of the handout.
  - Total the scores in each of the areas, multiply that by two for the total score.
  - The score only reflects which learning style or styles are typically or most effectively used by the learner. The scores are not meant to be used as comparative information, one style is not "better" or more effective than another.
- When finished, present the **Learning Styles** handout and transparency **(H8/T8)**.
- Have the participants share with the group which learning style they fall into.
- Review and discuss each learning style as a group. Emphasize that the participants should use the information gained from participating in this activity as a source of personal reflection regarding their own learning style and as an awareness of the possible learning styles of others.

Goal 3: Know the risk factors that may prohibit or impede typical development.

3.1 Lecture: Risk Factors

Present the **Risk Factors** handout and transparency **(H9/T9)**.

There are several factors that may lead to a child having developmental and other disabilities. They may be genetic or they may be environmental, and they may occur during the prenatal, natal, or postnatal periods.

Physical and other characteristics for all people are shaped by our genes. They determine whether we are tall or short, bald or have brown or red hair, the color of our eyes, and more. Sometimes disabilities and other conditions are inherited as a result of the genes that exist in our parents. Many times a child's parents do not have the disability; they carry the genes from earlier generations. Genetic causes may cause mild or severe disabilities that may or may not be life threatening. Examples of genetically caused disorders are Down Syndrome, Hemophilia, P.K.U., Rhetts Syndrome, Sickle Cell Anemia and more.

Sometimes circumstances in a child's environment may cause the child to have a disability. Toxins in the air, water pollution, and lead poisoning are other factors that may have an impact on a child's environment and lead to a disability. For example, a child's family may have economical or other disadvantages that make it difficult to provide experiences that stimulate or encourage learning.

Many disabilities are the result of something happening to the fetus while it is still in the mother's womb, prenatally. If the mother has poor nutrition, has hepatitis or measles, uses drugs, alcohol, or smokes, her child may be born with a disability. Other factors that have been linked to these conditions are medicines taken during pregnancy and food additives.

Some disabilities result from conditions present at the time of birth, natally. Being born prematurely, having a loss of oxygen, long labor, excessive hemorrhaging or loss of blood for the mother, early separation of the placenta, and direct injury to the head if instruments are used are some events during the birth process that may cause disabilities.

Other risk factors include:

- An abusive adult figure in the home.

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- Mother and/or father was a teenager at time of birth.
- Low income.
- Educational level of parent (or parent figure) raising the child.
- In need of language development.
- Unemployment in the family.
- Frequent moves.
- Homelessness.
- Family history of learning problems.
- Low self-esteem.
- Poor social skills.
- Drug and/or alcohol abuse in the family.

Module B Handouts

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Module B: Overview of Human Growth, Development, and Learning

1. Identify major cognitive, affective, physical, and communicative milestones of typically developing children and youth.

2. Know basic styles of human learning.

3. Know risk factors that may prohibit or impede typical development.

Stages of Cognitive Development

0 - 2 years

- ***Causality:*** Understands relationships between cause and effect.
- ***Object Permanence:*** Remembering an object or person exists when not directly in sight.
- ***Imitation:*** Watching and then repeating the actions or sounds of another person.
- ***Spatial Relations:*** Organizing one's world in terms of the spatial location of objects, relationships between objects, and how objects change relationship when moved.
- ***Means to an End:*** Problem-solving used to obtain a desired want.
- ***Schemes:*** Patterns of action that represent one's understanding of objects.

2 - 6 years

- ***Reasoning:*** No systematic or logical process.
- ***Symbolic Function:*** The ability to use mental symbols.
- ***Deferred Imitation:*** The ability to imitate something after experiencing it at an earlier time.
- ***Symbolic Play***: The ability to pretend.
- ***Drawing:*** The ability to represent something on paper.
- ***Mental Imagery:*** The ability to create an image from a mental symbol (i.e., the word bicycle evokes an image of a two-wheeled vehicle).
- ***Language:*** The ability to vocalize with meaning.
- ***Egocentrism:*** The child cannot take the view of another person.
- ***Syncretism:*** The grouping together of unrelated events. "My bike is yellow and it made me fall down."
- ***Classification:*** The child can typically sort by color, shape, and size. The child will begin to use class names for objects but may not understand the logic of classes.
- ***Numbers:*** The child understands the concept of one-to-one correspondence.

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Stages of Cognitive Development

(continued)

7 - 11 years

- ***Action is internalized:*** The child is able to use a process of logical thinking to solve problems (can look at a maze and then draw correctly through it).
- ***Reversibility:*** The ability to understand that an object can have its original condition restored after changes have been made to its original shape (clay).
- ***Conservation:*** The ability to understand that substances remain the same despite changes that have been made in shape or physical arrangements (two equal lengths of string, one bent, are still the same length).
- ***Decenterization:*** The ability to focus on different attributes of a situation at one time (two block structures, one placed on low table the other on a high table. The child counts the blocks to see if they are equal height).
- ***Counting:*** Counts by 2s and 10s.
- ***Correspondence:*** The ability to recognize that quantities are the same even if they are physically transformed.
- ***Classification:*** The ability to understand one object can be in two classes at the same time (a blue block can be a block or wooden material).
- ***Time:*** The child masters clock time, then calendar time, then years and dates.
- ***Cause and Effect:*** The ability to use hypothetical deductive reasoning to explain cause and effect relationships (a spinning wheel always stops at the same spot. The child will identify a variable and devise a way to test the variable to see if it influences the wheel stopping).

11+ years

- ***Abstraction:*** The ability to use abstractions.
- ***Reasoning:*** Reasoning abilities are supported by logic. The ability to reason, solve problems, and recognize there are multiple possibilities for solutions to a problem.
- ***Ability to think about possibilities that are separate from the actual situation at hand.***
- ***Understands metaphors.***
- ***Deductive Reasoning:*** The ability to form theories, develop hypotheses and derive logical deductions.
- ***Inductive Reasoning:*** The ability to make general conclusions based on observation.
- ***Critical Thinking:*** The ability to think in terms of ideals, which leads the adolescent to become more of a critic.

Stages of Physical Development

0 - 3 months
- Obtains control over the position of the head.
- Holds his/her head up when lying on the stomach and in the sitting position.
- Voluntary grasp reflex.
- Swats at objects.

3 - 6 Months
- Rolls over in both directions.
- Sits for a brief time with no support.
- Practices moving legs and feet.
- Can be supported in a standing position.
- Visually directs grasp to obtain toys.
- Explores one object at a time.
- Adapts reach toward an object.
- Grasps toys with their fingers.

6 - 9 Months
- Gets in and out of the sitting position.
- Prepares for crawling.
- Pulls themselves up on furniture.

9 - 12 Months
- Crawling is efficient.
- Experiments with climbing.
- Walks around with support.
- Develops a pincer grasp.
- Releasing motor skill.

12 - 24 Months
- Coordinated walking.
- Balances on one foot.
- Begins running.
- Stacks blocks.
- Scribbles imitations of writing strokes.

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Stages of Physical Development
(continued)

2 - 7 years
- Experiments with running and stopping.
- Hops and skips.
- Walks across a balance beam.
- Throws a ball and retains balance.
- Uses tricycles or other pedal toys.
- Jumps from heights.
- Begins climbing on jungle gyms.
- Cuts with scissors.
- Strings beads.
- Draws with a pencil or crayon.
- Imitates building structures with blocks.
- Imitates or copies strokes or letters using a pencil or crayon.
- Completes simple puzzles.

7 - 11 years
- Growth slows down.
- Becomes proportionately thinner.
- Increased coordination in gross motor skills.
- Increased muscle strength.
- Proficient in roller skating, skipping rope, biking, soccer, and baseball.
- Develops eye-hand coordination.
- Increased ability to write.

11+ years
- Puberty.
- Rapid physical growth spurt.
- Further development of sex organs.
- Increase in strength and coordination.
- Reproduction is possible

Stages of Affective Development

0 - 2 years

- Learns to adjust and adapt to his/her social environment.
- Temperament may be "easy," "difficult," or "slow-to-warm-up."
- Attachments are developed.
- Distinguishes his/her caregivers from others.
- Seeks caregivers presence.
- Develops sense of security which allows exploration.
- Has a fear of strangers.
- Develops gazing, smiling, and vocalizing.
- If not engaged in play, will observe events of interest.
- Plays independently with little effort to interact with children nearby.
- Begins to observe other children in play.
- Becomes aware of self as a separate being.
- Cries to get their way.
- Laughs in anticipation.
- Anger occurs when caregiver leaves, toy taken away, etc.

2 - 7 years

- Social maturity develops. Increasing amount of interaction with other children.
- Growing sense of independence.
- Parallel play develops, two or more children playing side-by-side.
- Associative play develops. Begins to play in unorganized groups of two or three.
- Cooperative play develops. Group-play is organized with a common goal.
- No constancy in friends (3 - 4-year-olds).
- Favorite friends begin to emerge (4 - 5-year-olds).
- Role identification develops. Children begin to view themselves as being similar to an adult with whom they have contact.
- Increased fear of imaginary creatures, the dark, etc.
- Anger occurs when in conflict and language is added to responses.
- Jealousy occurs more in home relationships.
- Growing ability to show affection.

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Stages of Affective Development

(continued)

7 - 11 years

- Dependence on peers.
- Development of self-concept.
- Development of sex roles.
- Develops a unique dress code, rules of behavior, and language.
- Conformity develops.
- Development of morals. Understands standards of right and wrong.
- Increased capacity for self-help.
- Develops the ability to sympathize and express compassion for others.
- Develops fears regarding schoolwork, social relationships, illness, death, and economic difficulties.
- Decrease in physical aggression.

11+ years

- Develops a strong sense of self.
- Peer group becomes the single most important influence.
- Concerns center around appearance.
- Preoccupied with own thoughts, personality, athletic abilities, and social skills.
- Concerned with how their family appears to others.
- Development of a vocational identity.
- Develops a moral identity. Begins to develop an idea of what ought to be.

Stages of Communication Development

0 - 1 month
- Differentiated cry.
- Social smile.
- Shows positive responses to adults talking to him/her.

1 - 4 months
- Participates in vocal play.
- Laughs.
- Blends vowel sounds together.
- Makes sounds with objects in mouth.
- Experiments with sounds.
- Establishes turn-taking games.
- Anticipates events with situational cues.

4 - 8 months
- Differentiates sound of toys/people.
- Increased variety of sounds (both vowels and consonants).
- Looks or acts to start or repeat a game.
- Recognizes familiar people and routines.
- Babbles.

8 - 12 months
- Differentiated sounds for wants.
- Uses simple jargon.
- Single words (mama and dada).
- Babbles.
- Initiates familiar games with a variety of signals.
- Recognizes words with situational cues.
- Uses a “gimme reach.”

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Stages of Communication Development

(continued)

12 - 18 months

- Increased single word vocabulary.
- Names familiar objects.
- Imitates novel sounds/words.
- Uses objects in social exchanges.

18 - 24 months

- Two-word sentences (nouns, verbs).
- Uses elaborate jargon.
- Speech-to-speech responses.
- Rapid vocabulary increases.
- Refers to absent objects.

2 - 7 years

- Average vocabulary:
  - 3-year-olds = 900
  - 4-year-olds = 1500
  - 5-year-olds = 2200
- Typical sentence length:
  - 3-year-olds = 3-4 words
  - 4-year-olds = 5-6 words
  - 5-year-olds = 6+ words
- Pronunciation:
  - 3-year-olds mispronounces 40% of speech.
  - 4-year-olds mispronounce 20% of speech sounds.
  - 5-year-olds mispronounce 10% of speech sounds.
- First words are nouns, then verbs.
- Most articulation problems are eliminated by 7 years of age.
- Develops repetition.
- Monologues form. Uses lengthy utterances while talking to self.
- Collective monograph develops. Simultaneous talk between two children with no interaction.

Stages of Communication Development

(continued)

2 - 7 years (continued)

- Associates actions with others. Child talks to self, but is aware someone is listening.
- Quarreling, expresses a need to be understood.
- Primitive arguments. Disagrees and gives differing point of view.
- Collaboration of abstract thought. Discusses a topic not shared in an activity.
- Genuine argument. The child uses the word "because."

7 - 11 years

- Exchanges thoughts with the people around him/her.
- Makes subjective value judgments.
- Questions to obtain information.
- Attempts to influence the actions of others.
- Will learn to use 5,000 new words.
- Will read 50,000 words.
- Increased ability to use compound and complex sentences.

11+ years

- Continued vocabulary acquisition and ability to express complex ideas and explanations in a logical sequential manner.

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Child Development Review

1. Jennifer cries each morning when her mother goes to work.
2. Sally refuses to go to school because she thinks her clothes make her different from the other girls.
3. Danny bats a toy repeatedly and watches it move.
4. Larry is afraid to admit that he scored an "A" on the test because his girlfriend failed.
5. Billy shares toys with his friend.
6. Brenda cuts with scissors and rides a trike.
7. Jeff knows what to do when he misses the bus and will be late for work.
8. Jenny loves to play board games and insists everybody play by the rules.
9. Sam draws a simple face with no arms or legs.
10. Suzi sits by herself and puts blocks in a box.
11. Mary talks Deanna into skipping school.
12. Jack is embarrassed about the way his dad dresses.

C.I.T.E Learning Styles Inventory

Least Like Me	Most Like Me		
1	2 3 4	1.	When I make things for my studies, I remember what I have learned better.
1	2 3 4	2.	Written assignments are easy for me to do.
1	2 3 4	3.	I learn better if someone reads a book to me than if I read silently to myself.
1	2 3 4	4.	I learn best when I study alone.
1	2 3 4	5.	Having assignment directions written on the board makes them easier to understand.
1	2 3 4	6.	It's harder for me to do a written assignment than an oral one.
1	2 3 4	7.	When I do math problems in my head, I say the numbers to myself.
1	2 3 4	8.	If I need help in the subject, I will ask a classmate for help.
1	2 3 4	9.	I understand a math problem that is written down better than one I hear.
1	2 3 4	10.	I don't mind doing written assignments.
1	2 3 4	11.	Written assignments are easy for me to do.
1	2 3 4	12.	I remember more of what I learn if I learn it when I am alone.
1	2 3 4	13.	I would rather read a story than listen to it read.
1	2 3 4	14.	I feel like I talk smarter than I write.
1	2 3 4	15.	If someone tells me three numbers to add I can usually get the right answer without writing them down.
1	2 3 4	16.	I like to work in a group because I learn from the others in my group.
1	2 3 4	17.	Written math problems are easier for me to do than oral ones.
1	2 3 4	18.	Writing a spelling word several times helps me remember it better.
1	2 3 4	19.	I find it easier to remember what I have heard than what I have read.
1	2 3 4	20.	It is more fun to learn with classmates at first, but it is hard to study with them.
1	2 3 4	21.	I like written directions better than spoken ones.
1	2 3 4	22.	If homework were oral, I would do it all.
1	2 3 4	23.	When I hear a phone number, I can remember it without writing it down.
1	2 3 4	24.	I get more work done when I work with someone.
1	2 3 4	25.	Seeing a number makes more sense to me than hearing a number.
1	2 3 4	26.	I like to do things like simple repairs or crafts with my hands.
1	2 3 4	27.	The things I write on paper sound better than when I say them.
1	2 3 4	28.	I study best when no one is around to talk or listen to.
1	2 3 4	29.	I would rather read things in a book than have the teacher tell me about them.
1	2 3 4	30.	Speaking is a better way than writing if you want someone to understand what you really mean.

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C.I.T.E Learning Styles Inventory
(continued)

Least Like Me	Most Like Me		
1	2 3 4	31.	When I have a written math problem to do, I say it to myself to understand it better.
1	2 3 4	32.	I can learn more about a subject if I am with a small group of students.
1	2 3 4	33.	Seeing the price of something written down is easier for me to understand than having someone tell me the price.
1	2 3 4	34.	I like to make things with my hands.
1	2 3 4	35.	I like tests that call for sentence completion or written answers.
1	2 3 4	36.	I understand more from a class discussion than from reading about a subject.
1	2 3 4	37.	I remember the spelling of a word better if I see it written down than if someone spells it out loud.
1	2 3 4	38.	Spelling and grammar rules make it hard for me to say what I want to in writing.
1	2 3 4	39.	It makes it easier when I say the numbers of a problem to myself as I work it out.
1	2 3 4	40.	I like to study with other people.
1	2 3 4	41.	When teachers say a number I really don't understand it until I see it written down.
1	2 3 4	42.	I understand what I have learned better when I am involved in making something for the subject.
1	2 3 4	43.	Sometimes I say dumb things, but writing gives me time to correct myself.
1	2 3 4	44.	I do well on tests if they are about things I hear in class.
1	2 3 4	45.	I can't think as well when I work with someone else.

Calculate Your Score

Visual Language	**Social-Individual**	**Visual Numerical**
5-	4-	9-
13-	12-	17-
21-	20-	25-
29-	28-	33-
37-	45-	41-
Total ____ ***x 2 =*** ____	***Total*** ____ ***x 2 =*** ____	***Total*** ____ ***x 2 =*** ____

C.I.T.E Learning Styles Inventory
(continued)

Auditory Language
3-
11-
19-
36-
44-
Total ____ ***x 2 =*** ____

Auditory Numerical
7-
15-
23-
31-
39-
Total ____ ***x 2 =*** ____

Kinesthetic-Tactile
1-
18-
26-
34-
42-
Total ____ ***x 2 =*** ____

Social-Group
8-
16-
24-
32-
40-
Total ____ ***x 2 =*** ____

Expressiveness-Oral
6-
14-
22-
30-
38-
Total ____ ***x 2 =*** ____

Expressiveness-Written
2-
10-
27-
35-
43-
Total ____ ***x 2 =*** ____

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Learning Styles Descriptions

Auditory Language

- Learns from hearing words spoken.
- He/she may vocalize or move his/her lips or throat while reading, particularly when striving to understand new material.
- He/she will be more capable of understanding and remembering words or facts that have been learned by hearing.

Visual Language

- Learns well from seeing words in book, on the chalkboard, charts, or workbooks.
- He/she may write down words that are given orally, in order to learn by seeing them on paper.
- This person remembers and uses information better if he/she has read it.

Auditory Numerical

- Learns from hearing numbers and oral explanations.
- Remembering telephone and locker numbers is easy, and he/she may be successful with oral number games and puzzles.
- This person may do just as well without his math book, for written materials are not important.
- He or she can probably work problems in his/her head, and may say numbers out loud when reading.

Visual Numerical

- Must see numbers on the board, in a book, or on a paper in order to work with them.
- He/she is more likely to remember and understand math facts when they are presented visually, but doesn't seem to need as much oral explanation.

Learning Styles Descriptions

(continued)

Auditory-Visual-Kinesthetic Combination

- Learns best by doing, becoming involved with the material.
- He/she profits from a combination of stimuli.
- The manipulation of material along with accompanying sight and sounds (words and numbers seen and heard) will aid his/her learning.
- They may not seem to understand or be able to concentrate or work unless totally involved.
- He/she seeks to handle, touch, and work with what he/she is learning.

Individual Learner

- Gets more work done alone.
- He/she thinks best and remembers more when the learning has been done alone.

Group Learner

- Prefers to study with at least one person and will not get as much done alone.
- He/she values others' opinions and preferences.
- Group interaction increases his/her learning and later recognition of facts.

Oral-Expressive

- Prefers to tell what he/she knows.
- He/she talks fluently, comfortably, and clearly.
- This person may know more than written tests show.
- He/she is probably less shy than others about giving reports or talking.
- Muscular coordination involved in writing may be difficult for this person.
- Organizing and putting thoughts on paper may be too slow and tedious for this student.

Written-Expressive

- Prefers to write fluent essays and good answers on tests to show what he/she knows.
- He/she feels less comfortable when oral answers or reports are required.
- His/her thoughts are better organized on paper than when they are given orally.

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Risk Factors

- Causes of Disabilities
- Genetic Factors
- Environmental Factors
- Prenatal
- Natal
- Other Risk Factors

Module B Transparencies

Module B: Overview of Human Growth, Development, and Learning

OrSpedB-T1

- ***Identify the major cognitive, physical, and communicative milestones of typically developing children and youth.***

- ***Know basic styles of human learning.***

- ***Know the risk factors that may prohibit or impede typical development.***

How Do Children Develop?

- *"Development is more than a series of steps."*
- *There are principles of development.*
- *Development is predictable.*
- *There are developmental milestones.*
- *Developmental opportunities are necessary.*
- *There are developmental stages.*
- *Individuals differ greatly.*

Stages of Cognitive Development

- *0 - 2 years*
  - *Sensorimotor Stage*
  - *Ability to interact using senses and motor capabilities.*
- *2 - 7 years*
  - *Preoperational Stage*
  - *Ability to use mental symbols.*
- *7 - 11 years*
  - *Concrete Operational Stage*
  - *Ability to use mental problem-solving strategies in concrete situations.*
- *11+ years*
  - *Formal Operational Stage*
  - *Ability to use abstractions.*

Stages of Physical Development

- ***The acquisition of motor skills and learning to physically control one's own body.***

- ***Changes in body include muscles, bones, and the nervous system.***

Stages of Affective Development

- ***The acquisition of feelings about self and others.***

- ***The acquisition of beliefs, skills, values, and behavior patterns necessary for interaction with others.***

Stages of Communication Development

- ***Acquiring the ability to interact with the environment using speech or other symbolic system.***

- ***Acquisition of ever increasing vocabulary.***

Child Development Review

1. ***Jennifer cries each morning when her mother goes to work.***

2. ***Sally refuses to go to school because she thinks her clothes make her different from the other girls.***

3. ***Danny bats a toy repeatedly and watches it move.***

4. ***Larry is afraid to admit that he scored an "A" on the test because his girlfriend failed.***

5. ***Billy shares toys with his friend.***

6. ***Brenda cuts with scissors and rides a trike.***

Child Development Review
(continued)

7. ***Jeff knows what to do when he misses the bus and will be late for work.***

8. ***Jenny loves to play board games and insists everybody plays by the rules.***

9. ***Sam draws a simple face with no arms or legs.***

10. ***Suzi sits by herself and puts blocks in a box.***

11. ***Mary talks Deanna into skipping school.***

12. ***Jack is embarrassed about the way his dad dresses.***

Learning Styles

- ***Auditory-Language***
- ***Visual-Language***
- ***Auditory-Numerical***
- ***Visual-Numerical***
- ***Auditory-Visual-Kinesthetic Combination***
- ***Individual Learner***
- ***Group Learner***
- ***Oral-Expressive***
- ***Written-Expressive***

Risk Factors

- ***Causes of Disabilities***
- ***Genetic Factors***
- ***Environmental Factors***
- ***Prenatal***
- ***Natal***
- ***Other Risk Factors***

Module C: Overview of Exceptionalities

Orientation to Special Education
Module C: Overview of Exceptionalities

A. Module Goals

Using the **Module C: Overview of Exceptionalities** handout and transparency **(H1/T1)**, review the goals of the module.

1. Know how beliefs about people with disabilities are related to life experiences.
2. Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.
3. Know categories of exceptionality according to state and federal laws.
4. Recognize the cognitive, communicative, physical, and affective needs that students may have as a result of a disability.
5. Know how to access information about specific disabilities, syndromes, and medical conditions on the internet, through libraries, and other sources.

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Goal 1: Know how beliefs about people with disabilities are related to life experiences.

1.1 Lecture: Hierarchy of Needs

Abraham Maslow

Present the **Maslow's Hierarchy of Needs** handout and transparency **(H2/T2)**. Review the hierarchy and the needs that all human beings experience. The first, most basic and fundamental needs are to have food, shelter, water and warmth, then to be safe, then the need for belonging and love becomes a priority. Most people find these within families, spouses or community. Emphasize that the needs of people with handicapping conditions are the same as those experienced by the typical population.

Norman Kunc

Note to Instructor: The following information is adapted from an article, The Importance of Belonging, in the 1992 Inclusion Conference Newsletter. Norman Kunc was born with cerebral palsy, he is a family therapist and educational consultant, and is well known as a champion of inclusion in the disability arena. He has a Master's degree and is the author of "Ready, Willing, and Disabled."

Schools have changed the concept of belonging from an essential and inherent human right to something that children have to earn. Kunc says that, "uniformity and perfection have become the criteria for belonging," and that "people are excluded because of their diversity." Kunc feels that the educational system has inverted Maslow's Hierarchy of Needs, making belonging and love dependent on first having reached the self-esteem level, stressing achievement and mastery of the curriculum. Kunc maintains that a sense of belonging and feeling good about who they are is essential *before* a student can begin to master the curriculum. Present the **Maslow's Hierarchy of Needs Revised** handout and transparency **(H3/T3)** to illustrate this point.

Kunc provides two ways an individual can have their need for self-esteem met.

1. Through achievement and mastery in certain areas, and
2. Through recognition and respect from others.

Only after this need is met, can individuals pursue their own unique gifts or talents.

Often students with disabilities are taken out of regular classes and told that they don't

belong. Kunc says this happens because "they don't walk the same way, talk the same way, or do the same curriculum. They are told when they learn these things they may return." Present the **Catch 22** handout **(H4)**. "Of course, we have a perfect Catch 22. Children with disabilities can't belong until they learn the skills, but they can't learn the skills because they are never allowed to belong." So, they are caught. Worse yet, their lack of progress in segregated classes is seen as more evidence of the need for segregation. Kunc refers to this as a form of "systemic child abuse."

Schools can look outside their own environments to see how other groups create belonging successfully. Kunc uses the analogy of street gangs. He says gangs are successful precisely because they satisfy the need for belonging.

1.2 Activity: Perceptions of People with Handicapping Conditions

Paraeducators will participate in an activity which provides an opportunity to reflect on their own perceptions of people with handicapping conditions.

1.2.1 Steps

- Present the **Friendship** transparency **(T4)**.
- Divide the participants into groups of four to five.
- Have each groups discuss and generate a list of
  - Perceptions they may have had in the past regarding people with handicapping conditions, and
  - New perceptions they may have after the previous lecture.
- When finished, have the groups share with the class their lists. Use this as an opportunity to engage the class in a discussion regarding how beliefs about people with handicapping conditions are related to an individual's life experiences.

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Goal 2: Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

2.1 Discussion: People-First Language

Ask the participants to provide examples of words and phrases associated with disabilities and people with handicapping conditions, both negative and positive, and write these on the **People-First Language** transparency **(T5)**. Examples:

- "He's mentally retarded,"
- "I work with CP kids,"
- "The significant-needs kids,"
- "SPED,"
- "The really low kids,"
- "Do you have any Downs kids in your class,"
- "He's handicapped," and
- "Can't really do anything."

Pose the following questions to the group, asking for responses:

- How do you feel when you hear these words?
- How would a person with a disability feel?
- Why are we concerned about words and names people use?
- How are words connected to feelings?

Referring back to the previously generated list of words and phrases, ask the participants to rephrase each item to reflect the proper usage of people-first language. Examples that correspond to the previously provided example might be:

- "He has mental retardation,"
- "I work with students who have CP,"
- "Kids who have significant needs," etc.

Engage the participants in a discussion about how their response to the above questions would differ from the first list to the second.

Goal 3: Know categories of exceptionality according to state and national laws.

3.1 Lecture: Categories of Exceptionality

Present the **Categories of Exceptionalities** handout and transparency **(H5/T6)**. Explain that these are the categories that are defined and designated to meet state and national laws and that students must meet the criterion for these handicapping conditions in order to qualify for services related to those conditions. Explain that these handicapping conditions are the most commonly addressed conditions within a public school community.

3.2 Lecture: Mental Retardation

Present the **Mental Retardation** handout **(H6)**. Individuals who have mental retardation have lower than average intelligence and tend to learn more slowly than their peers in the areas of social interactions, cognitive growth, and motor development.

Approximately 10% of any public school population has handicapping conditions that qualify for special services. These conditions include, but are not limited to, learning, speech and language, visual and hearing, emotional, and cognitive disabilities. This 10% includes the 3% of the public schools' population that has mental retardation.

Note to Instructor: The information for this lecture was adapted from Adams, 1987.

Characteristics:

- Significant delays in social adaptive behavior.
- Slower progression through the stages of cognitive development.
- Memory and attention problems.
- More passive, high expectancy of failure.

Present the **Normal Distribution of IQ Scores** handout and transparency **(H7/T7)**.

Acronyms and terms associated with mental retardation include:

- SLIC: Severely Limited Intellectual Competency (CO)
- EMR: Educable Mentally Retarded; IQ between 50 and 70,
- TMR: Trainable Mentally Retarded; IQ between 25 and 50
- SPH: Severe-Profound Handicapped: IQ 25 and below

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- Developmentally Handicapped or Delayed
- Slow Learners

Another term for EMR is Mild Mental Retardation. TMR is also known as Moderate Mental Retardation. These terms are more often preferred in inclusive educational settings because of the possible stigma and lack of dignity attached to the words "educable" and "trainable."

What is mental retardation?

- An individual is considered to have mental retardation based on the three criteria.
  - Intellectual functioning level (IQ) is below 70 - 75;
  - Significant limitations exist in two or more adaptive skill areas; and
  - The condition is present from childhood (defined as age 18 or less) (AAMR, 1992).

What are the adaptive skills essential for daily functioning?

- Adaptive skill areas are those daily living skills needed to live, work, and play in the community. They include communication, self-care, home living, social skills, leisure, health and safety, self-direction, functional academics (reading, writing, basic math), community use, and work. Adaptive skills are assessed in the person's typical environment across all aspects of an individual's life. A person with limits in intellectual functioning who does not have limits in adaptive skill areas may not be diagnosed as having mental retardation.

3.2.1 Discussion: Adaptive Behavior

Engage the participants in a discussion about the impact of adaptive behavior skills on life-long opportunities for people with mental retardation. Ask the participants to provide of examples of adaptive behaviors and discuss any questions that arise.

How many people are affected by mental retardation?

- The Arc reviewed a number of prevalence studies in the early 1980s and concluded that 2.5 to 3% of the general population have mental retardation (The Arc, 1982). Based on the 1990 census, an estimated 6.2 to 7.5 million people have mental retardation. Mental retardation is 10 times more common than cerebral palsy and 28 times more prevalent than neural-tube defects such as spina bifida. It affects 25 times as many people as blindness (Batshaw, 1997). Mental retardation cuts across the

lines of racial, ethnic, educational, social, and economic backgrounds. It can occur in any family. One out of ten American families is directly affected by mental retardation.

How does mental retardation affect individuals?

- The effects of mental retardation vary considerably among people, just as the range of abilities varies considerably among people who do not have mental retardation. About 87% will be mildly affected and will be only a little slower than average in learning new information and skills. As children, their mental retardation is not readily apparent and may not be identified until they enter school. As adults, many will be able to lead independent lives in the community and will no longer be viewed as having mental retardation.
- The remaining 13% of people with mental retardation, those with IQs under 50, will have serious limitations in functioning. However, with early intervention, a functional education and appropriate supports as an adult, all can lead satisfying lives in the community.

How is mental retardation diagnosed?

- The AAMR process for diagnosing and classifying a person as having mental retardation contains three steps and describes the system of supports a person needs to overcome limits in adaptive skills.
  1. Have a qualified person give one or more standardized intelligence tests and a standardized adaptive skills test, on an individual basis,
  2. Describe the person's strengths and weaknesses across four dimensions.
     - i. Intellectual and adaptive behavior skills,
     - ii. Psychological/emotional considerations,
     - iii. Physical/health/etiological considerations, and
     - iv. Environmental considerations.
     - ➥ Strengths and weaknesses may be determined by formal testing, observations, interviewing key people in the individual's life, interviewing the individual, interacting with the person in his or her daily life, or a combination of these approaches.
  3. An interdisciplinary team is to determine needed supports across the four dimensions. Each support identified is assigned one of four levels of intensity.
     - i. Intermittent.

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- Refers to support on an "as-needed basis." An example would be support that is needed in order for a person to find a new job in the event of a job loss. Intermittent support may be needed occasionally by an individual over the lifespan, but not on a continuous daily basis.

ii. Limited,
- May occur over a limited time span, such as during transition from school to work or in time-limited job training. This type of support has a limit on the time that is needed to provide appropriate support for an individual.

iii. Extensive, and
- Assistance that an individual needs on a daily basis that is not limited by time. This may involve support in the home and/or support in work.

iv. Pervasive.
- Pervasive support refers to constant support across environments and life areas, and may include life-sustaining measures. A person requiring pervasive support will need assistance on a daily basis across all life areas. Intermittent, limited, and extensive supports may not be needed in all life areas for an individual.

What does the term mental age mean when used to describe the person's functioning?

- The term mental age is used in intelligence testing. It means that the individual received the same number of correct responses on a standardized IQ test as the average person of that age in the sample population. Saying that an older person with mental retardation is like a person of a younger age or has the "mind" or "understanding" of a younger person is incorrect usage of the term. The mental age only refers to the intelligence test score, it does not describe the level and nature of the person's experience and functioning in aspects of community life.

What are the causes of mental retardation?

- Mental retardation can be caused by any condition which impairs development of the brain before birth, during birth, or in the childhood

years. Several hundred causes have been discovered, but in about one-third of the people affected, the cause remains unknown. The major known causes of mental retardation are Down Syndrome, Fetal Alcohol Syndrome, and Fragile X. The causes can be categorized as follows:

- Genetic Conditions
  - These result from abnormality of genes inherited from parents, errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, overexposure to x-rays, and other factors. More than 500 genetic diseases are associated with mental retardation. Some examples include:
    - PKU (phenylketonuria), a single gene disorder, also referred to as an inborn error of metabolism because it is caused by a defective enzyme.
    - Down Syndrome, a chromosomal disorder. Chromosomal disorders happen sporadically and are caused by too many or too few chromosomes, or by a change in the structure of a chromosome.
    - Fragile X, a single gene disorder located on the X chromosome and is the leading inherited cause of mental retardation.
- Problems During Pregnancy
  - Use of alcohol or drugs by the pregnant mother can cause mental retardation.
  - Recent research has implicated smoking in increasing the risk of mental retardation.
  - Other risks include malnutrition, certain environmental contaminants, and illnesses of the mother during pregnancy (toxoplasmosis, cytomegalovirus, rubella, and syphilis). Pregnant women who are infected with HIV may pass the virus to their child, leading to future neurological damage.
- Problems at Birth
  - Although any birth condition of unusual stress may injure the infant's brain, prematurity and low birth weight predict serious problems more often than any other conditions.
- Problems after Birth
  - Childhood diseases such as whooping cough, chicken pox, measles, and Hib disease, which may lead to meningitis and encephalitis, can damage the brain.
  - Accidents, such as a blow to the head or near drowning.

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- ⇉ Lead, mercury, and other environmental toxins can cause irreparable damage to the brain and nervous system.

- ➥ Poverty and Cultural Deprivation
  - ⇉ Children in poor families may become mentally retarded because of malnutrition, disease-producing conditions, inadequate medical care, and environmental health hazards.
  - ⇉ Children in disadvantaged areas may be deprived of many common cultural and day-to-day experiences provided to other youngsters.
  - ⇉ Research suggests that such under-stimulation can result in irreversible damage and can serve as a cause of mental retardation.

Can mental retardation be prevented?

- During the past 30 years, significant advances in research have prevented many cases of mental retardation. For example, every year in the United States, we prevent:
  - ➥ 250 cases of mental retardation due to phenylketonuria (PKU) by newborn screening and dietary treatment;
  - ➥ 1,000 cases of mental retardation due to congenital hypothyroidism because of newborn screening and thyroid hormone replacement therapy;
  - ➥ 1,000 cases of mental retardation due to the use of anti-Rh immune globulin to prevent Rh disease and severe jaundice in newborn infants;
  - ➥ 5,000 cases of mental retardation caused by Hib diseases due to the use of the Hib vaccine;
  - ➥ 4,000 cases of mental retardation due to measle encephalitis because of the use of the measles vaccine; and
  - ➥ Untold numbers of cases of mental retardation caused by rubella during pregnancy due to the rubella vaccine (Alexander, 1998).
- Other interventions have reduced the chance of mental retardation. Removing lead from the environment reduces brain damage in children. Preventive interventions such as child safety seats and bicycle helmets reduce head trauma. Early intervention programs with high-risk infants and children have shown remarkable results in reducing the predicted incidence of subnormal intellectual functioning. Early, comprehensive prenatal care and preventive measures prior to and during pregnancy increase a woman's chances of preventing mental retardation. Pediatric AIDS is being reduced by AZT treatment of the mother during pregnancy, and dietary

supplementation with folic acid reduces the risk of neural-tube defects. Research continues on new ways to prevent mental retardation, including research on the development and function of the nervous system, a wide variety of fetal treatments, and gene therapy to correct the abnormality produced by defective genes.

Note to Instructor: The preceding information was found online at http://www.thearc.org. Their resource list included the following:

- American Association on Mental Retardation. (1992). Mental Retardation: Definition, Classification, and Systems of Supports, 9th Edition. Washington, DC.
- Alexander, D. (1998). Prevention of Mental Retardation: Four Decades of Research. Mental Retardation and Developmental Disabilities Research Reviews. 4: 50-58
- Batshaw, M. (1997). Children With Disabilities. Baltimore: Paul H. Brookes Publishing Co.
- The Arc. (1982). The Prevalence of Mental Retardation. (out-of-print).

3.3 Lecture: Learning Disabilities

An individual with learning disabilities evidences a gap between the potential to learn and performance. A person may have difficulty with visual perception but is not blind, difficulty with auditory perception but is not hard of hearing, and/or difficulty with cognitive learning but is not retarded.

Note to Instructor: The following information was adapted from Adams, 1987.

Characteristics:

- Low academic skills, especially in reading, writing, and spelling,
- Trouble following directions.
- Memory and attention problems.
- Lack of social skills.
- Motor problems (poor coordination).
- Scattered performance.
- Difficulty generalizing.

Acronyms and phrases associated with learning disabilities include:

- MBD: Minimal Brain Dysfunction
- PC: Perceptual-Communicative
- Hyperactive

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- ADD: Attention Deficit Disorder
- Neurological Impairment
- LD: Learning Disabled

3.4 Lecture: Communication Disorders

Often communication disorders accompany other handicapping conditions, such as Mental Retardation, Cerebral Palsy, Learning Disabilities, Autism, or Multiple Disabilities. Of the children with special education needs, 25% have communication disroders. There are five features of communication:

- Phonology (sounds)
- Morphology (word structures)
- Syntax (sentence structures)
- Semantics (word meanings)
- Pragmatics (functions of speech; the different rules for different situations, may be motoric, verbal, or vocal)
- Speech/Language competency includes:
- Receptive Understanding (hearing and cognition)
- Expressive Communication (cognition and speaking)
- Cognitive Understanding (intelligence)
- Interactive Skills (social confidences)
- Physical and Motor Facial Expressions (supportive gestures, tongue, lip, throat, etc.)

3.5 Lecture: Emotional/Behavioral Disorder

Individuals with emotional or behavioral disorders display one or more of the following characteristics over a period of time with unusual intensity.

Note to Instructor: The following informaion was adapted from Adams, 1987.

Characteristics:

- Often frustrated or upset.
- Temper tantrums.
- Constantly moving.
- Few or no friends.
- Avoids participation with peers.
- Seeks constant reassurance.

- Often ill.
- Soils or wets self.
- Unprovoked emotional outbursts.

3.6 Lecture: Hearing Impairments

If a person cannot hear the ordinary sounds of activity around him, he is considered deaf. In people with normal hearing, sound enters the outer ear, travels through the ear canal, passes through the eardrum into the middle ear, then to the auditory nerve, which sends the message to the brain. If the individual hears only a part of what is being said, they are said to be hard-of-hearing. A hearing loss may be mild, moderate, severe, or profound.

Note to Instructor: The following information is from Cashdollar and Martin, 1981.

Characteristics:

- Most individuals who have a hearing problem were born with the loss (mother had German measles or rubella during pregnancy).
- We often think that if we talk a little louder, the individual can hear us, when in fact, he simply cannot hear certain sounds used in speech because of their intensity or frequency.
- Many individuals with hearing impairments wear hearing aids. Aids do not correct the loss, they magnify or amplify all sounds, including background noises.
- Oral and written language production is often delayed due to the inability to hear.

3.7 Lecture: Visual Impairments

An individual may be born with a visual impairment or acquire a visual disability through injury, disease, or old age.

Note to Instructor: The following information was adapted from Cashdollar and Martin, 1981.

Characteristics:

- People who are visually impaired can do almost everything people without visual impairments can do.
- People with visual impairments may use a cane, a partner, or a guide

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dog to help them travel.
- At home, or in a familiar environment, people with visual impairments rely on memory and the sense of touch.

Terms associated with visual impairments:
- Partially Sighted
  - ➥ Vision of 20/70 to 20/200 after corrections with lens.
- Legally Blind
  - ➥ Less than 20/200 vision with lens.
- Total Blindness
  - ➥ Cannot tell light from darkness.

3.8 Assignment: Further Research Regarding Exceptionalities

- Distribute the **Exceptionalities** assignment **(A1)**.
- Divide class into groups of two or three.
- Have each group pick a handicapping condition from the list that they would like to research.
- Explain to students that they will be expected to meet outside of class-time to do this research.
- They should use the provided URL's to research their choice. Students may also use libraries or other sources of written information, but they must use at least one internet source.
- Decide upon and list which condition groups will be reporting on prior to class dismissal so that there will not be research on same subject occurring.
- Each group needs to prepare an oral presentation regarding the handicapping condition they chose during the next class session.
- Each groups also needs to provide the instructor two or more URL's not included in the provided list, that address the handicapping condition that the group has chosen.

3.9 Lecture: Additional Forms of Handicapping Conditions

Additional handicapping conditions paraeducators may encounter include significantly limited intellectual competency of unknown etiology, autism, cerebral palsy, pervasive developmental disorder (PDD), and traumatic brain injury (TBI).

Distribute the **Additional Forms of Handicapping Conditions** handout **(H8)**. Briefly

review the handout. Explain that this handout provides information regarding autism and pervasive developmental disorder.

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Goal 4: Recognize the cognitive, communicative, physical, or affective needs that students may have as a result of a disability.

4.1 Discussion: Needs and Areas of Deficit

Present the **Needs and Areas of Deficit** handout and transparency **(H9/T8)**. Engage the participants in a discussion regarding the needs and deficit areas of students with specific disabilities. Ask the participants to provide specific examples of deficit areas or needs for each of the following areas:

- Mental Retardation.
- Learning Disabilities.
- Speech/Language Disabilities.
- Emotional/Behavioral Disorders.
- Hearing Impairments, and
- Visual Impairments.

4.2 Lecture: Typical Needs and Areas of Deficit

Needs Specific to Mental Retardation

- Rote learning of basic functional skills.
- Lots of opportunity to practice new skills in many different settings, many repetitions.
- More chance to practice skills.
- More time to complete tasks.
- Concentrated instruction in social and occupational areas.
- Involve parents as partners.
- Need concrete examples.
- Break complex tasks into simpler parts to be taught.
- Most teaching should occur in the environment in which the skill is most likely to be used.

Needs Specific to Learning Disability

- Individual and small group instruction.
- More time to complete tasks.
- Short, specific instructions.
- Extra help in academic areas.
- Shorter assignments.

- Established routine.
- Organizational strategies.
- Multi-modality approach.

Needs Specific to Speech/Language Disabilities

- Adaptations
- Simplify
- Model
- Re-verbalize
- Reinforce new skills
- Use multi-sensory modes
- Reduce complexity of sentences
- Use simple vocabulary
- Be more concrete
- For articulation, voice, and fluency:
  - Often direct instruction and therapy are needed to learn correct productions and procedures. The learner will also need help in using the new skills in real situations.
- For language problems:
  - Academic assistance.
  - Pragmatic skill training (working on the rules of communication involving modifying language according to the situation, the listener's characteristics, the intent of communication, or a combination of these).
  - More specifically:
    - Providing a good model of correct articulation and broad language use.
    - Ability to simplify verbal instructions.

Needs Specific to Emotional/Behavioral Disorders

- Adaptations in classroom environment.
- Consistent behavior management.
- External reinforcement.
- Affective skills development.
- Self-control training.
- Planned shaping of peer and adult relationships.
- Individual and family counseling.
- Social skill development.

Needs Specific to Hearing Impairments

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- Stand near the student; speak slowly and distinctly, and in simple terms.
- Opportunities to continue relationships with classmates to maintain or gain feeling of belonging.
- Call attention to visual aspects of a particular concept to be learned.
- Ask questions of the student occasionally to make certain he/she is following the discussion or instructions.

Needs Specific to Visual Impairments

- Adapted educational materials (cassette tape recorders, talking books, Braille Writer etc.
- Adapted classroom environment (openness, familiarity of objects).
- Extra time to complete assignments (due to fatigue or physical ability).
- Mobility training within the school environment.

Goal 5: Know how to access information about specific disabilities, syndromes, and medical conditions on the internet, through libraries, and other sources.

5.1 Discussion: Accessing Information

Ask the participants to briefly share the results of their homework assignment. Ask them to share the additional URL's they found that are associated with the handicapping condition their group chose with the class.

Note to Instructor: The activities to support this goal are included in the homework assignment using the internet as a source for their research.

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Module C Handouts

Module C: Overview of Exceptionalities

1. Know how beliefs about people with disabilities are related to life experiences.

2. Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value.

3. Know categories of exceptionality according to state and federal laws.

4. Recognize the cognitive, communicative, physical, and affective needs that students may have as a result of a disability.

5. Know how to access information about specific disabilities, syndromes, and medical conditions on the internet, through libraries, and other sources.

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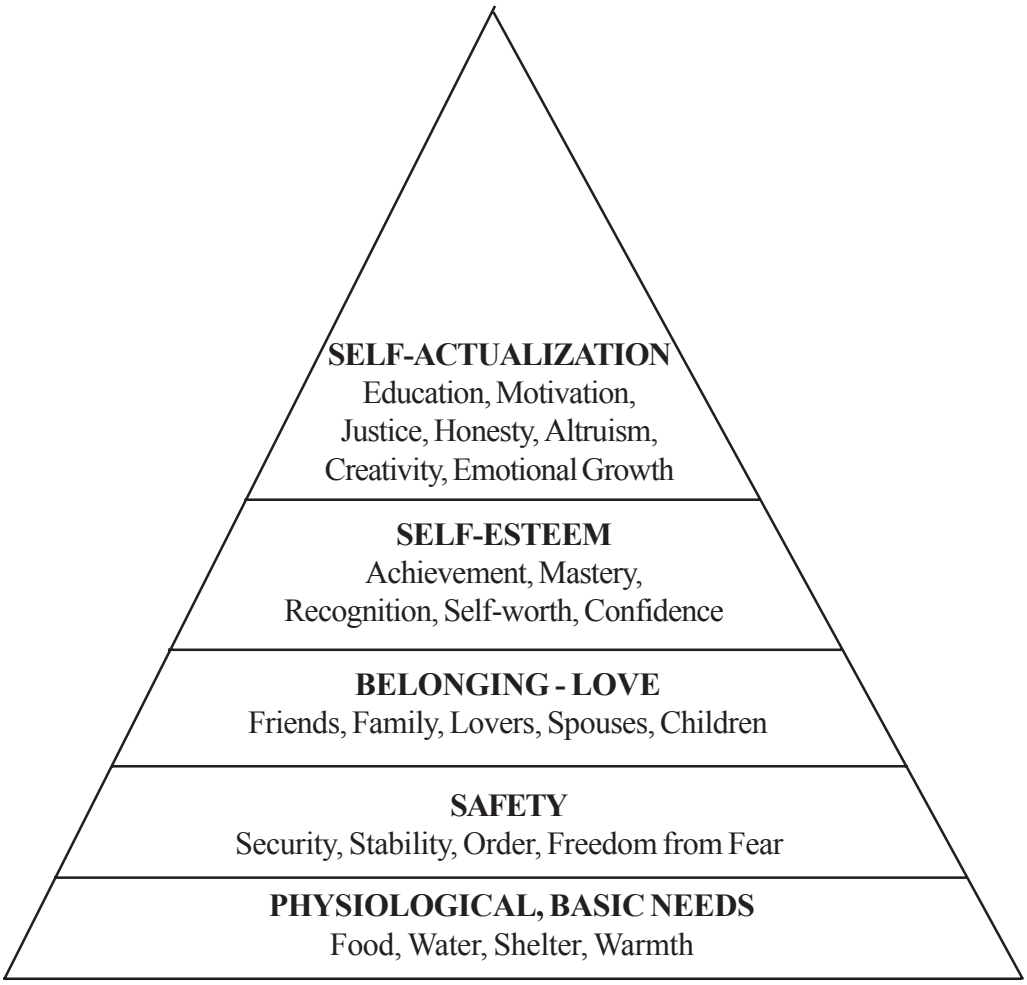
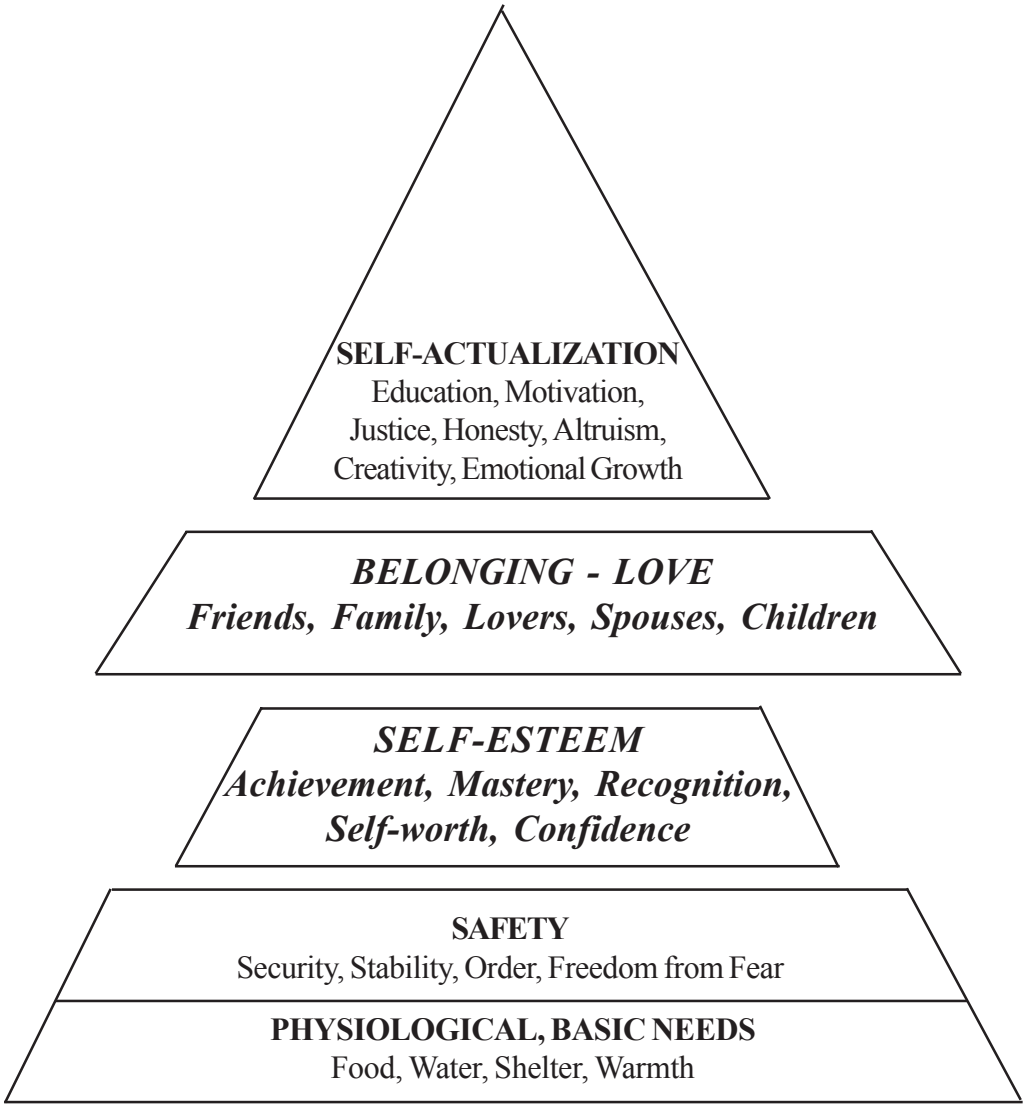
Maslow's Hierarchy of Needs



Maslow's Hierarchy of Needs Revised



The inversion of Maslow's hierarchy of human needs in 20th century reflect in Norman Kunc article "The Importance of Belonging" from the '92 Inclusion Conference newsletter.

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Catch 22

Kunc says, "Of course, we have a perfect Catch 22. Children with disabilities can't belong until they learn the skills, but they can't learn the skills because they are never allowed to belong." So they are caught.

Worse yet, their lack of progress in segregated classes is seen as more evidence of the need for their segregation. Kunc makes everyone squirm a little when he calls this a form of "systemic child abuse."

Schools can look outside their own environments to see how other groups create belonging successfully. Kunc uses the analogy of street gangs. He says gangs are successful precisely because they satisfy the need for belonging

The above article is from the '92 Inclusion Conference newsletter.

Categories of Exceptionality

- Mental Retardation (SLIC, EMR, TMR, SPH)
- Learning Disabilities (PC, MBD)
- Emotional/Behavioral Disorders
- Hearing Impairments
- Visual Impairments

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Mental Retardation

Individuals who have mental retardation have lower than average intelligence and tend to learn more slowly than their peers in the areas of social interactions, cognitive growth, and motor development.

Approximately 10% of any public school population has handicapping conditions that qualify for special services. These conditions include, but are not limited to, learning, speech and language, visual and hearing, emotional, and cognitive disabilities. This 10% includes the 3% of the public schools population that has mental retardation.

Characteristics:

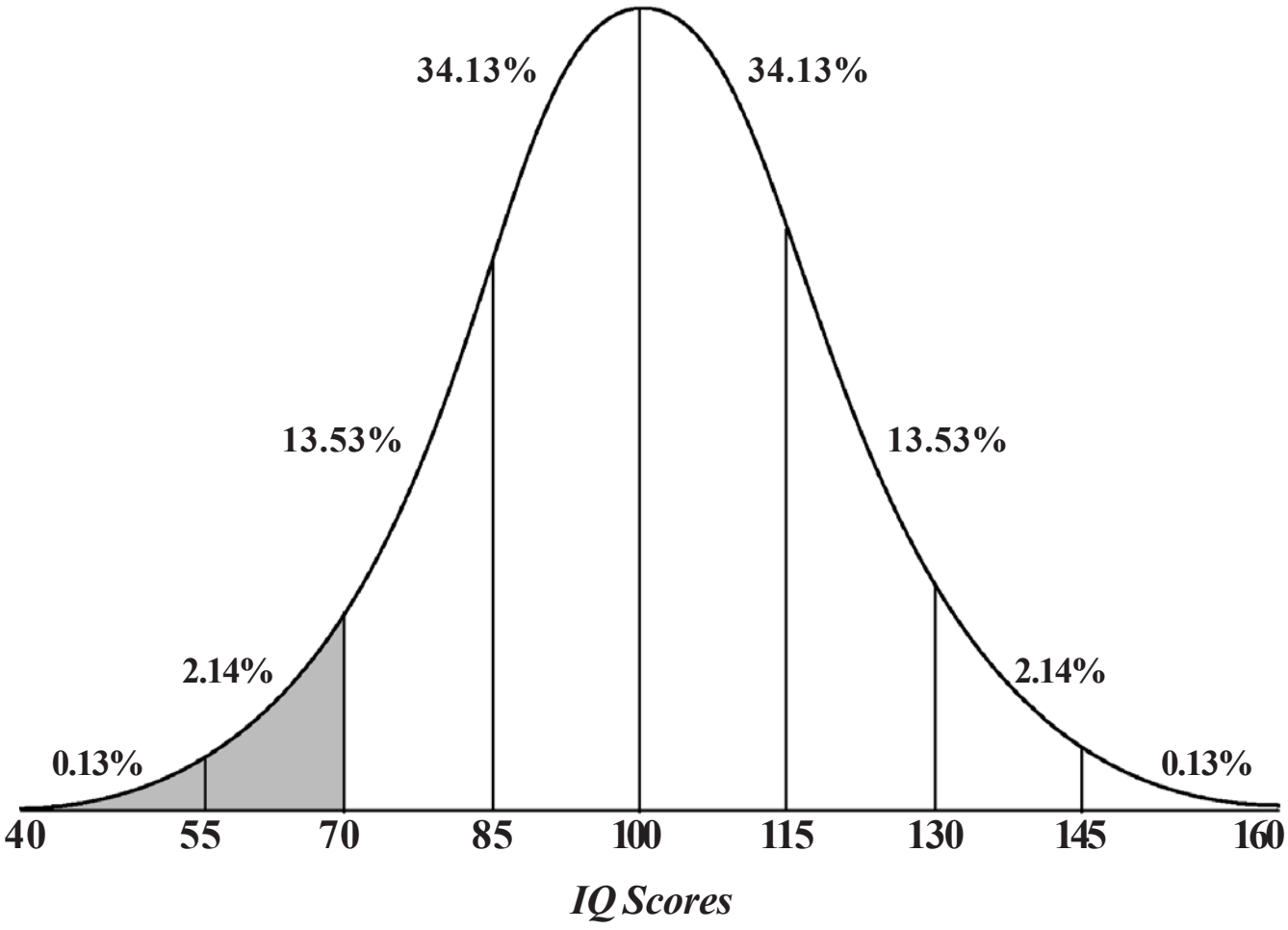
- Significant delays in social adaptive behavior.
- Slower progression through the stages of cognitive development.
- Memory and attention problems.
- More passive, high expectancy of failure.

Acronyms and terms associated with mental retardation include:

- SLIC: Severely Limited Intellectual Competency (CO)
- EMR: Educable Mentally Retarded; IQ between 50 and 70,
- TMR: Trainable Mentally Retarded; IQ between 25 and 50
- SPH: Severe-Profound Handicapped: IQ 25 and below
- Developmentally Handicapped or Delayed
- Slow Learners

Another term for EMR is Mild Mental Retardation. TMR is also known as Moderate Mental Retardation. These terms are more often preferred in inclusive educational settings because of the possible stigma and lack of dignity attached to the words "educable" and "trainable."

Normal Distribution of IQ Scores



Percent of General Population in Mentally Handicapped Range, 2.27%

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Additional Forms of Handicapping Conditions

It has been over 50 years since Dr. Leo Kanner, a psychiatrist at Johns Hopkins University, wrote the first paper applying the term "autism" to a group of children who were self-absorbed and who had severe social, communication, and behavioral problems. This paper provides a general overview of the complexity of this developmental disability by summarizing many of the major topics in autism.

Incidence

The most cited statistic is that autism occurs in 4.5 out of 10,000 live births. This is based on large-scale surveys conducted in the United States and England. In addition, the estimate of children having autistic-like behaviors is 15 to 20 out of 10,000. Interestingly, estimates on the prevalence of autism vary considerably depending on the country, ranging from 2 out of 10,000 in Germany to as high as 16 out of 10,000 in Japan. Possible reasons for the discrepancy in prevalence rates may be due to differing diagnostic criteria, genetic factors, and/or environmental influences.

Autism is three times more likely to affect males than females. This gender difference is not unique to autism since many developmental disabilities have a greater male to female ratio.
Major characteristics:

- Many infants who have autism are different from birth. Two common characteristics they may exhibit include arching their back away from their caregiver to avoid physical contact and failing to anticipate being picked up (i.e., becoming limp). As infants, they are often described as either passive or overly agitated babies. A passive baby refers to one who is quiet most of the time making little, if any, demands on his/her parents. An overly agitated baby refers to an infant who cries a great deal, sometimes non-stop, during his/her waking hours. During infancy, many begin to rock and/or bang their head against the crib; but this is not always the case.

In the first few years of life, some toddlers who have autism reach developmental milestones, such as talking, crawling, and walking, much earlier than the average child; whereas others are considerably delayed. Approximately one-third of children who have autism develop normally until somewhere between 1 1/2 to 3 years of age; then autistic symptoms begin to emerge. These individuals are often referred to as having 'regressive' autism. Some people in the field believe that candida albicans, vaccinations, exposure to a

Additional Forms of Handicapping Conditions
(continued)

virus, or the onset of seizures may be responsible for this regression. It is also thought that some children with "regressive" autism may have Landau-Kleffner Syndrome (see next section).

During childhood, children who have autism may fall behind their same-aged peers in the areas of communication, social skills, and cognition. In addition, dysfunctional behaviors may start to appear, such as self-stimulatory behaviors (i.e., repetitive, non-goal directed behavior, such as rocking, hand-flapping), self-injury (e.g., hand-biting, head-banging), sleeping and eating problems, poor eye contact, insensitivity to pain, hyper-/hypo-activity, and attention deficits.

One characteristic which is quite common in autism is the individual's insistence on "sameness" or "perseverative" behavior. Many children become overly insistent on routines; if one is changed, even slightly, the child may become upset and tantrum. Some common examples are: drinking and/or eating the same food items at every meal, wearing certain clothing or insisting that others wear the same clothes, and going to school using the same route. One possible reason for "insistence on sameness" may be the person's inability to understand and cope with novel situations.

Individuals who have autism sometimes have difficulty with the transition to puberty. Approximately 20% have seizures for the first time during puberty which may be due to hormonal changes. In addition, many behavior problems can become more frequent and more severe during this period. However, others experience puberty with relative ease.

In contrast to 20 years ago when many individuals who have autism were institutionalized, there are now many flexible living arrangements. Usually, only the most severe individuals live in institutions. In adulthood, some people with autism live at home with their parents; some live in residential facilities; some live semi-independently (such as in a group home); and others live independently. There are adults who have autism who graduate from college and receive graduate degrees; and some develop adult relationships and may marry. In the work environment, many adults who have autism can be reliable and conscientious workers. Unfortunately, these individuals may have difficulty getting a job. Since many of them are socially awkward and may appear to be 'eccentric' or 'different,' they often have difficulty with the job interview.

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Additional Forms of Handicapping Conditions
(continued)

The following description of Pervasive Developmental Disorder is referenced from: DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, fourth edition, 1994, published by the American Psychiatric Association, Washington, D.C.

Pervasive Developmental Disorders
"Pervasive Developmental Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age. This section contains Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asberger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. These disorders are usually evident in the first years of life and are often associated with some degrees of Mental Retardation, which, if present, should be coded on Axis II. The Pervasive Developmental Disorders are sometimes observed with a diverse group of other general medical conditions (e.g., chromosomal abnormalities, congenital infections, structural abnormalities of the central nervous system.). If such conditions are present, they should be noted on Axis III,. Although terms like 'psychosis" and "childhood schizophrenia" were once used to refer to individuals with these conditions, there is considerable evidence to suggest that the Pervasive Developmental Disorders are distinct from schizophrenia (however, an individual with Pervasive Developmental Disorder may occasionally later develop schizophrenia).

Source: http://www.autism.org/overview.html

The following information regarding Traumatic Brain Injury is from the internet source: http://www.biact.org/infartcl/inf010.html

Needs and Areas of Deficit

- Mental Retardation
- Learning Disabilities
- Speech/Language Disabilities
- Emotional/Behavioral Disorders
- Hearing Impairments
- Visual Impairments

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Module C Assignments

Exceptionalities

Angelman Syndrome Information
http://people.zeelandet.nl/fhof/angelman/asi.htm

Asperger Syndrome
http://info.med.yale.edu/chldstdy/autism/asperger-basic.html

Autism
http://www.autism-society.org/packages/educating_children

Cerebral Palsy
http://www.ucpa.org

Charge Syndrome
http://www.kume.edu/gec/support/charge.html

Cornelia de Lange Syndrome
http://edlsoutreach.org/facts.html

Chromosome 6 Ring
http://www.nord-rdb.com

Chromosome 9, Trisomy Mosaic
http://www.stepstn.com/nord/rdb_sum/1035.htm

5p-Syndrome
http://www.fivepminus.org/about/ovsyn.htm

Deafness and Hearing Loss
http://www.nichcy.org

Distal Trisomy 10q Families
http://www.proaxis.com

Down Syndrome
http://www.nichcy.org

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Exceptionalities
(continued)

Duchenne Muscular Dystrophy
http://www.mentalhelp.net

Fetal Alcohol Syndrome
http://www.mentalhelp.net

Fragile X Syndrome
http://www.mentalhelp.net

Hydrocephalus
http://neurosurgery.mgh.harvard.edu/ha/fact-sht.htm

Klinefelter Syndrome
http://www.mentalhelp.net

Landau-Kleffner Syndrome
http://www.ninds.nih.gov/healinfo/disorder/landau/landauhtm

Marfan Syndrome
http://www.mentalhelp.net

Pierre Robin Syndrome
http://www.nord-rdb.com

PKU (phenylketonuria)
http://www.mentalhelp.net

Prader-Willi Syndrome (PWS)
http://www.pwsausa.org/medalert.htm

Rett Syndrome
http://www2.paltech.com/irsa/whatis.htm

Severe and/or multiple disabilities
http://www.nichcy.org

Exceptionalities
(continued)

Sotos Syndrome
http://www.mentalhelp.net

Speech and Language Disorders
http://www.nichcy.org

Spina Bifida
http://www.nichcy.org

Tay-Sachs Disease
http://www.nichcy.org

Table on Genetic Disorders
http://www.kumc.edu/ama-mss/study/table_of_genetic_disorders.htm

Traumatic Brain Injury
http://www.nichcy.org

Tuberous Sclerosis
http://www.eagles.bbs.net.au

Visual Impairments
http://www.nichcy.org

Williams Syndrome
http://www.mentalhelp.net

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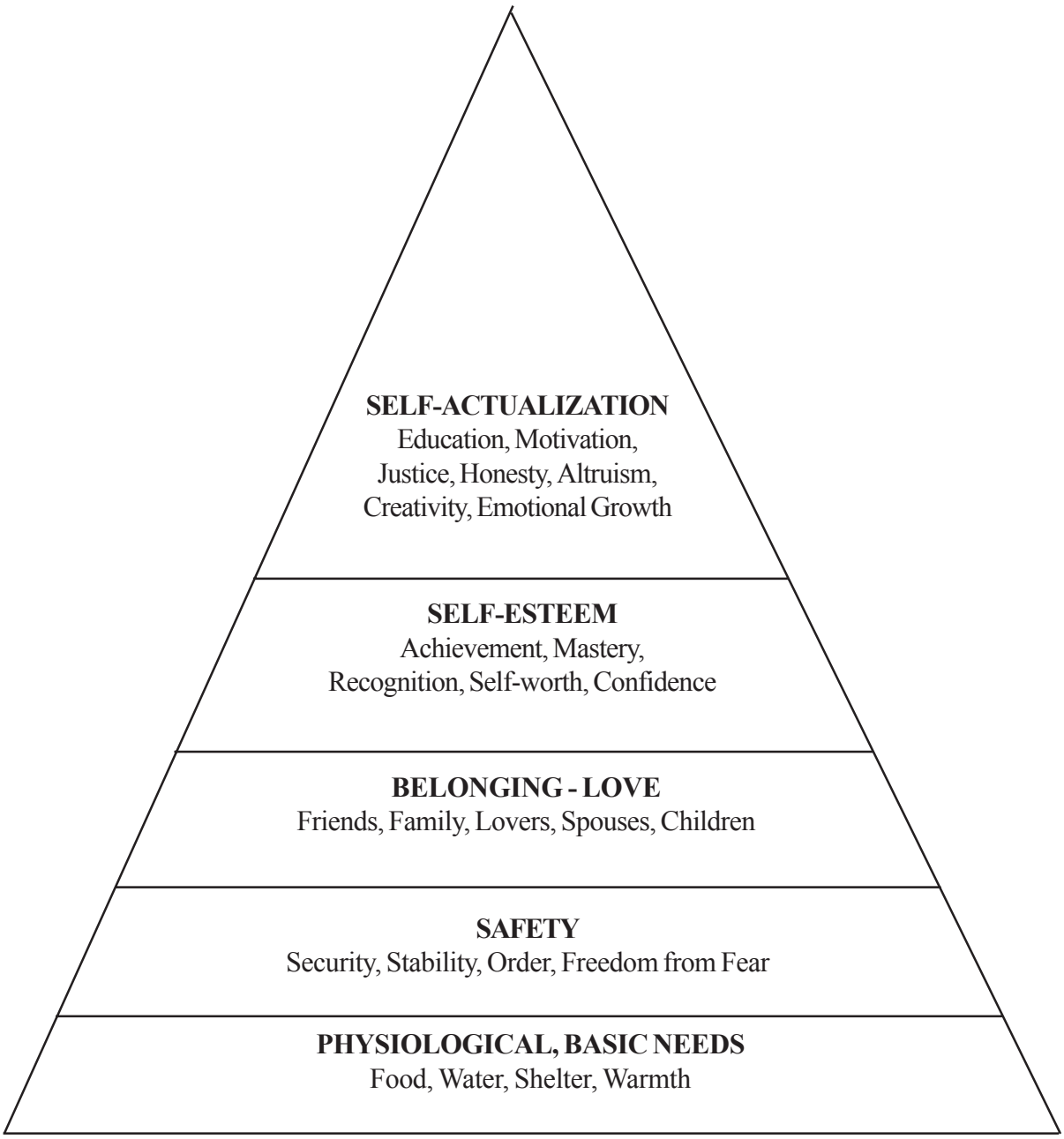
Module C Transparencies

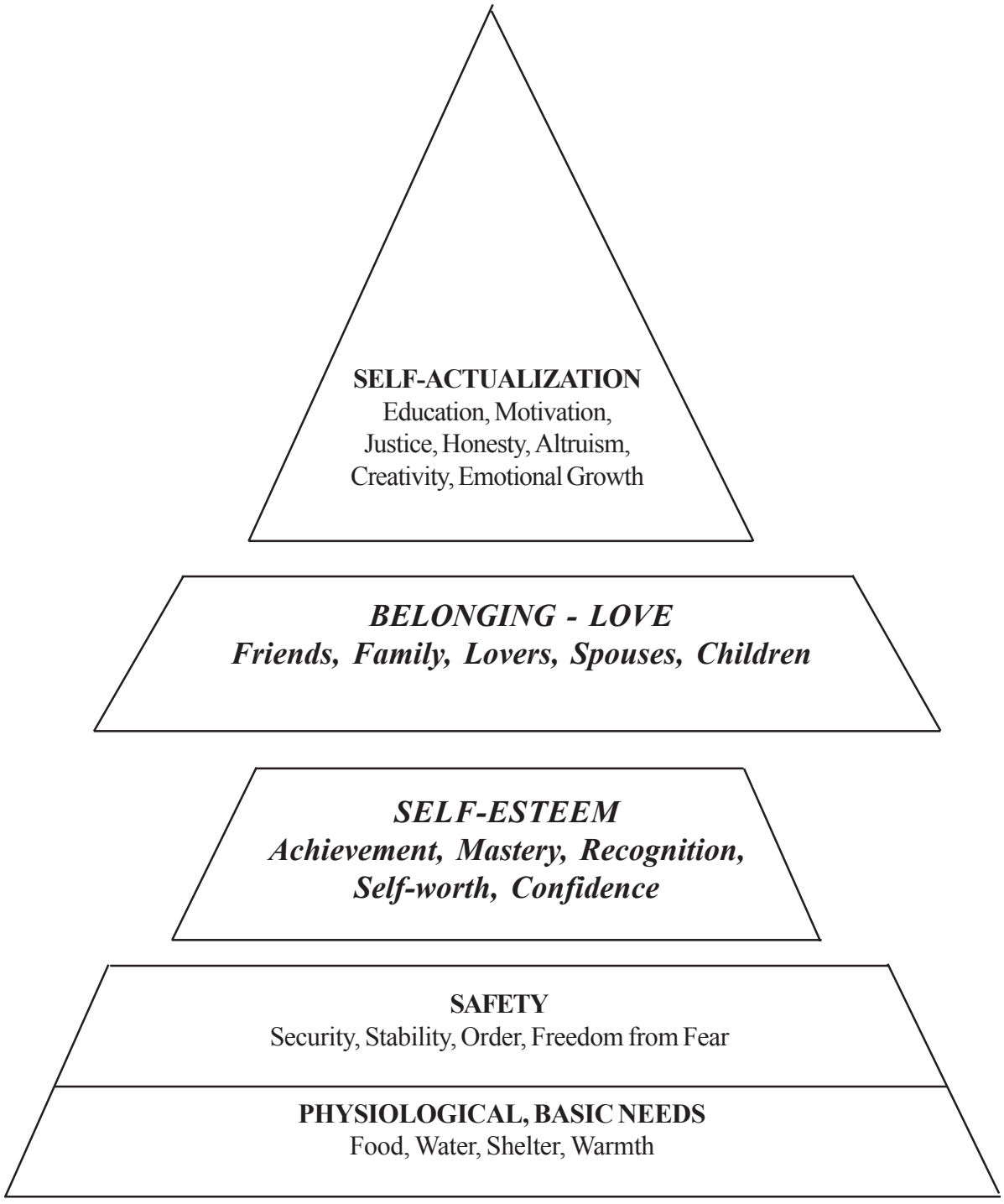
Module C: Overview of Exceptionalities

- ***Know how beliefs about people with disabilities are related to life experiences.***
- ***Use people-first language by talking and writing about people with disabilities in ways that honor their dignity and respect their value***
- ***Know categories of exceptionality according to state and federal laws.***
- ***Recognize the cognitive, communicative, physical, and affective needs that students may have as a result of a disability.***
- ***Know how to access information about specific disabilities, syndromes, and medical conditions on the internet, through libraries, or other sources.***

Maslow's Hierarchy of Needs



Maslow's Hierarchy of Needs Revised



Friendship

"Friendship is about choice and chemistry; it cannot be readily defined much less forced… We can create and foster an environment in which it is possible for friendship to emerge."

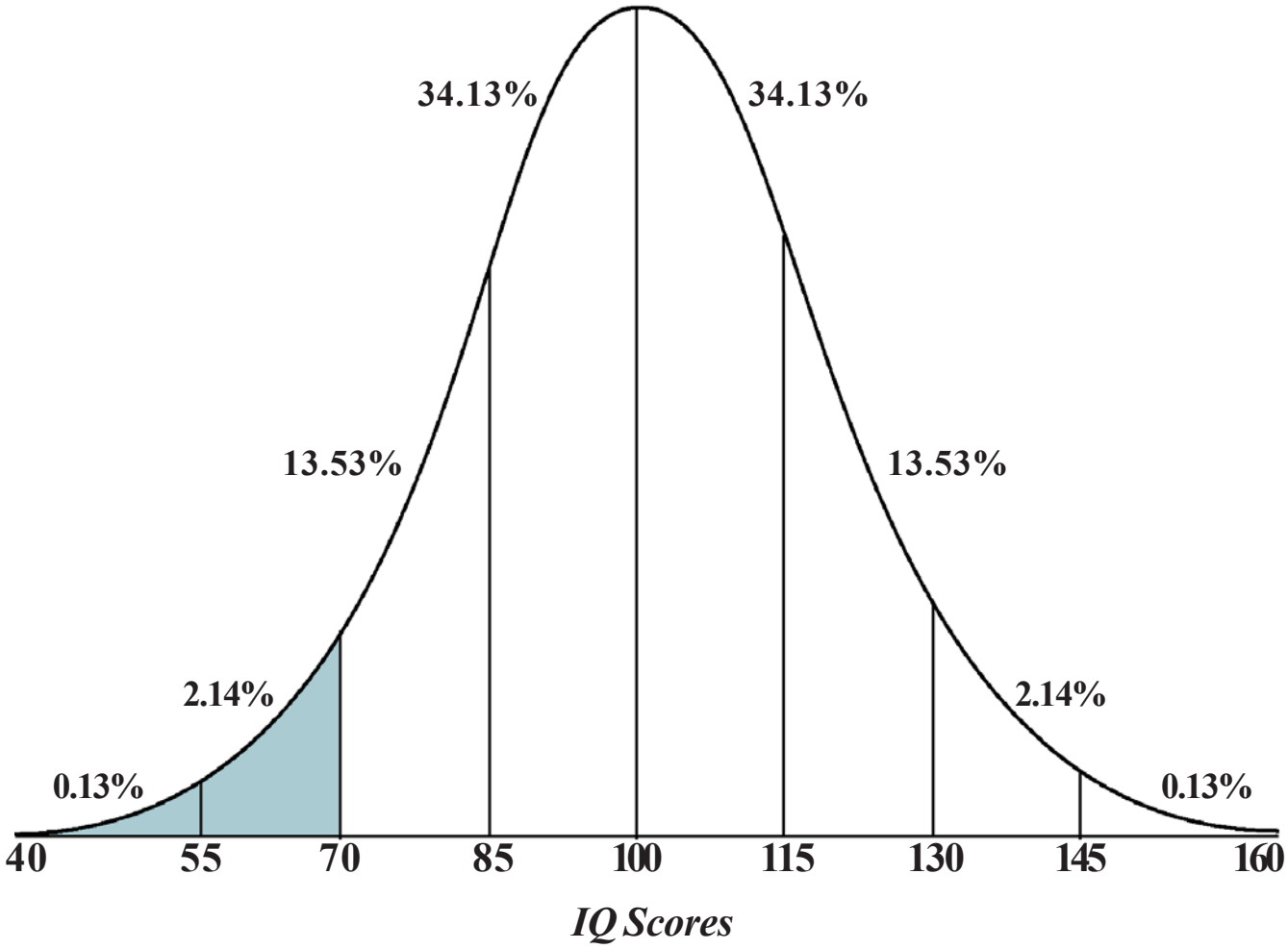
Van der Klift and Kunc, 1994

People-First Language

Categories of Exceptionality

- ***Mental Retardation (SLIC, EMR, TMR, SPH)***
- ***Learning Disabilities (PC, MBD)***
- ***Emotional/Behavioral Disorders***
- ***Hearing Impairments***
- ***Visual Impairments***

Normal Distribution of IQ Scores



- ***Percent of General Population in Mentally Handicapped Range, 2.27%***

Needs and Areas of Deficit

- ***Mental Retardation***
- ***Learning Disabilities***
- ***Speech/Language Disabilities***
- ***Emotional/Behavioral Disorders***
- ***Hearing Impairments***
- ***Visual Impairments***

Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities

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Orientation to Special Education Academy
Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities

A. Module Goals

Using the **Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities** handout and transparency **(H1/T1)**, review the goals of the module.

1. Know written health, safety, and emergency procedures and practices.
2. Know responsibilities and practices associated with maintaining the physical health and safety of students.
3. Know the obligation of all school personnel to report child abuse, suicidal ideation, and/or dangerous behavior.
4. Know techniques that promote interactions and facilitate friendships among students with and without disabilities.

A.1 Discussion: Further Understanding the Goals

Referring back to Maslow's Hierarchy of Needs, from Module C, engage the participants in a brief discussion regarding the connection between the levels in the hierarchy and the goals of this unit. Discussion should include information that ties the component parts of the hierarchy (safety, well-being, belonging, etc.) to the purpose of the direct contact and assistance that students receive from educational personnel.

Note to Instructor: Many of the component parts of this module are specific to particular school districts. It is to the benefit of the participants to provide forms and information from the school district the academy is being taught in, making handouts and transparencies as needed (e.g., health care plans, forms for documentation of medication delivery). Many school districts have videos available through the school health office or school nurses that serve as excellent resource support for this module.

Goal 1: Know written health, safety, and emergency procedures and practices.

1.1 Lecture: Confidentiality and Privacy

State and federal laws regulate access to information about students with disabilities, specifically, The Family Rights and Privacy Act (Rule 51) and the Individuals with Disabilities Education Act (IDEA). These acts address issues regarding the privacy of students and their parents.

As team members, paraeducators will have information about students that is privileged and confidential. Confidentiality includes all aspects of the student's education and life that would not typically be known without specific explanation, just as in the life of a peer who does not have a handicapping condition. This may include information such as specific disability or handicapping condition, family or home situation, social history of student and/or family, assessment information gathered from the IEP, etc.

Note to Instructor: Further information regarding breaches of confidentiality and direct implications to the paraeducator may be reviewed and discussed at this time. It is to the benefit of the participants to review procedures specific to their school district regarding confidentiality and privacy.

1.2 Activity: Understanding Confidentiality

Paraeducators will participate in an activity that will further facilitate their understanding of confidentiality.

1.2.1 Steps

- Divide the class into several small groups.
- Have the groups discuss scenarios that typically occur within the school or community setting. These scenarios should include questions that members of the school community or public might typically ask regarding the handicapping conditions of the individuals that paraeducators may be teaching.
- Provide chart paper for the groups to record examples of questions that are typically asked and examples of appropriate answers that can be given to those questions that still regard the confidentiality, rights, and dignity of the individual student.

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- Have the groups share their lists with the class. Discuss any issues or questions that arise.

1.3 Lecture: Roles and Responsibilities of Paraeducators

What is the role of the paraeducator?
The role of the paraeducator is to provide support for education in the classroom. This takes many different forms: small-group instruction, monitoring student activities, etc. Paraeducators have typically worked either in a traditional classroom setting or in classrooms with students who have special needs, and many work as aides in school health rooms. Until recently, only school health aides and paraeducators in classrooms with students with special needs were faced with the possibility of providing medical services to students. As more and more students with multiple needs are included in daily educational settings in traditional classrooms and into typical schools, all paraeducators and teachers are faced with the prospect of providing some sort of medical or physical support service for some of their students. These services can range from very basic to extremely complex, intrusive procedures.

Various school personnel maintain various roles and responsibilities in the areas of school health and safety. School mental health team members often serve as a resource specific to the mental health and emotional well being of students. They often are the team members referred to when questions arise regarding abuse or neglect of children.

As school personnel are increasingly required to perform medical procedures, concerns arise regarding job descriptions and requirements, school conditions, and available facilities, staff training and competencies, and liability, as well as the overall concern for providing a safe and healthy environment for all students. Court decisions have mandated that schools provide for many medical procedures. As a result, laws have been enacted that require the designation of personnel and specific training of those personnel in order to carry out procedures in a safe and appropriate manner.

1.4 Lecture: Nurse Delegatory Information

There are legal limitations placed on school personnel. Every state has a Nurse Practice Act that outlines the responsibilities of all health professionals. The Nurse Practice Act requires that only a person educated and licensed to practice as a registered nurse, unless he or she has trained another person and is confident of that person's ability to carry out the trained procedure, can perform medical procedures.

The school health professional, in most cases a school nurse either on site or on call, is legally responsible for providing appropriate medical services to students. The school health professional may delegate the provision of a service if he/she has trained and certified other school personnel to provide that service. Service can only be provided directly to the person for whom the training was designated, the training cannot carry over and be used for another student with a like disability. Use the **Delegation** transparency **(T2)** to emphasize that whether the school health professional (or nurse) has trained other personnel and delegated the responsibility or not, the school health professional is still legally responsible.

All paraeducators, both in the classroom and in the health room, work under the direct supervision of the school principal but are generally directed on a day-to-day basis by the special education or classroom teacher or the school nurse. In the case of directions to provide medical services, paraeducators can be delegated tasks only by a health professional and cannot legally be directed to provide medical services by any other person. Even with this provision, there are still limitations on the types of services non-medical personnel can provide.

1.5 Lecture: Liability

The school health professional's responsibility, if he or she has delegated provision of medical services, is to certify that school personnel have been appropriately trained to provide for retraining or updated training.

It is suggested that paraeducators be sure their training has been documented and signed-off on by the school nurse or the person who trained them.

Emphasize that whether non-medical personnel are responsible for providing medical services or not, they should still be trained in such areas as: proper lifting techniques, emergency procedures, background on federal and state law, etc.

1.6 Lecture: Health Care Plans

Individual school districts have their own forms for health care plans. These plans are used primarily to address the health care needs of individual students while they are in the school setting. The plans are used to ensure prompt and appropriate delivery of medical services to students who have ongoing health and medically related needs. A health care plan is not necessary for students who are temporarily taking medications such as antibiotics or anything that is short-term. Health care plans are recommended for all students who have

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chronic conditions such asthma, ADD, CP, catheterization needs, diabetes, etc. Many districts have very specific health care plans for students and require use of those forms for any ongoing health related problems.

Typically, at the beginning of the school year, a list of health problems is compiled by the medical professional in each building. Due to issues regarding confidentiality these lists may or may not be posted to all educational personnel. The information on these lists is delivered for the following reasons:

- To increase awareness of the school nurse and appropriate school personnel of the existence of students who have significant health related problems,
- To identify students who may require nursing follow-up and planned intervention to cope with chronic or significant conditions, or
- To facilitate adequate staff preparation and education regarding appropriate emergency measures that may be required for specified students.

These lists are derived from student emergency cards, health records, the previous year's list, and parent information and interview. The list is usually updated with new information obtained by the health care professional.

Note to Instructor: Locate health care plans and other health care forms from the specific school district this academy is being taught in. Make handouts and transparencies as needed to enhance this lecture.

1.7 Lecture: Documentation

What are protocols and why are they needed?
Protocols may include: descriptions of diseases or conditions, medical history, signs, symptoms, differential diagnosis, special instructions, and follow up care. Protocols may come in two forms:

1. General, and
   - Applying to any student; includes broad guidelines for observation, management, referral, and recommendations to the student, parent or school staff.
2. Individual.
   - An order written by the student's own doctor. It should be specific. Any physician's prescription, in itself, constitutes a standing order.

Protocols are typically used to assist health room workers identify common childhood

ailments and standing orders to assist in their management.

Protocols are guidelines. District policies must be followed. Healthroom workers and/or paraeducators who are asked to assist in any medically related capacity should be informed of what the district policies and protocols are.

Incident reports are another common form of documentation used by most schools. Present the **Incident Report** transparency **(T3)**. When an incident occurs at school, or on school grounds, the paraeducator may be asked to file an incident report. This report is used to, as accurately as possible, document any incident that occurs in the school setting that may involve students or staff and that might have impacted the safety and/or well being of the students or staff. A paraeducator may be asked to fill out a form for a specific incident or may request to fill out a form if they observe an incident that has not been reported by other school personnel. The forms are typically available in and managed by the school health office. The intent of the forms is to provide an immediate and prudent means of documentation for any incident that may affect the health and well being of the staff or students. An incident report should include:

- Nature of the incident;
- First aid given;
- Time, date, place of the incident;
- Injury; and
- Follow-up care given.

1.8 Lecture: Workman's Compensation

Any incident that involves an employee, that occurs during the workday and that includes an injury, or potential injury of any type (e.g. employee believes they may have strained their back but are not sure yet, it is just "a little sore"), should be reported to the school health official immediately. The school health official should direct the employee to fill out an incident report that will document the incident and the injury. The school health official will then direct the employee regarding further medical assistance that may be needed. Job-related injuries are covered under Workman's Compensation Insurance, provided through the employer, should cover the injury incurred, not the personal insurance of or at personal cost to the employee. The school district will have designated medical assistance providers for Workman's Compensation related injuries and will be able to direct the employee to the closest office for examination or checkup.

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Goal 2: Know responsibilities and practice associated with maintaining the physical health and safety of students.

2.1 Lecture: Responsibilities and Practices

Present the **Responsibilities and Practices** transparency **(T4)** and briefly review the following, explaining that each will be covered in greater depth later in the module.

- Universal Precautions
- Delivery of Medication
- Seizures
- Eating and the Heimlich Maneuver
- Restroom and Privacy Issues
- Hand-Washing
- Catheterization
- Transportation and Wheelchairs
- Lifting and Good Body Mechanics
- Positioning

2.2 Lecture: Universal Precautions

Research shows that the risk of getting a significant contagious disease (SCD) in a school setting is extremely small. However, school staffs need to decrease the possibility of exposure to bloodborne pathogens. Significant contagious disease includes: cytomegalovirus (CMV), hepatitis B virus (HBV), and human immunodeficiency virus (HIV) infections.

Universal precautions means protecting oneself from exposure to blood or bodily fluids through the use of latex gloves, masks, or eye goggles; cleaning blood or bodily fluid spills with soap and bleach solution and water; and disinfecting and incinerating or decontaminating infected water before disposing in a sanitary landfill.

Present the **Common Misconceptions About the Transmission of Bloodborne Pathogens** handout and transparency **(H2/T5)**, emphasizing that none of these are modes of transmission for bloodborne pathogens.

The use of universal precautions reduces the risk of exposure to bloodborne pathogens that are a result of contact with blood and bodily fluids. Most school districts demand the use of

universal precautions from their employees as a simple but highly reliable means of maintaining the health and safety of the employee.

Present the **Universal Precautions** handout and transparency **(H3/T6)**. Universal precautions includes:

- Attending to others.
  - Use a barrier when exposure to blood or body fluids is possible.
  - Bag soiled clothing.
  - Bag waste and used gloves or barriers.
  - Wash hands thoroughly.
- Attending to the environment.
  - Use gloves to clean.
  - Use disinfectant soaps.
  - Use disposable cleaning materials.
  - Disinfect affected areas.
  - Secure waste in bag for disposal.
- Attending to self.
  - Remove gloves and place in a plastic bag.
  - Immediately wash with disinfectant soaps.

Note to Instructor: Many school districts have videos available that give a clear and brief explanation of the use of universal precautions. Obtain and use this video, if possible.

Emphasize the critical importance of using universal precautions across the school day for any activity or procedure that could possibly put the paraeducator at risk of coming into contact with bodily fluids. Review your district's procedure for providing paraeducators with the appropriate materials (such as latex or non-latex gloves) to provide for their safety.

2.3 Discussion: Further Understanding Universal Precautions

Ask the participants to provide examples of where and when the use of universal precautions should occur for them in their own schools. Engage the participants in a discussion about how their examples compare to the previous lecture, referring to the **Universal Precautions** handout and transparency **(H3/T6)** to guide the discussion.

2.4 Lecture: Delivery of Medication

Briefly review the nurse delegatory information provided earlier in this module regarding the

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delivery of medication.

Present the **The Five Rights of Assisting with Medication** handout and transparency **(H4/T7)**. Emphasize that when delivering medication, after having been given the appropriate training to do so, triple check these "Five Rights" each time you give medication. This review will give you a systematic safety check and reduce your chance of making a mistake.

1. Right Student: Protect confidentiality. Is this the right student? Even if you think you know the student to whom you are giving the medication, double-check by asking his/her name or have another method of verification.
2. Right Medication: Make sure that you are giving the right medication. Compare the prescribing practitioner's written instructions to the medication log and the pharmacy label. Check expiration dates.
3. Right Dosage: Be sure to give the exact amount of medication specified by the legal prescribing practitioner's orders and the pharmacy label. The dosage on the medication bottle and the authorization should agree.
4. Right Time: Check the medication log for the time when the medication should be given and to determine if it has already been given that day.
5. Right Route: Check the medication order and the pharmacy label for the method, indicating the exact route for the medication to be given (e.g., by mouth, by injection).

2.5 Lecture: Seizures

Many students within the public school setting have some sort of seizure disorder. Typically, seizures are controlled with medication. There are, however, occasions when a student was not previously diagnosed with having seizures or when medication is not effective and a seizure will occur. There are specific steps that should be followed in dealing with these situations. Distribute and review the **Management of Seizures** handout **(H5)**.

Do...

- Lower person to the floor. If in a wheelchair, unstrap feet and loosen other straps, wait for assistance before removing from chair to floor.
- Loosen tight clothing that might interfere with breathing.
- Time the seizure and be observant of physical movement.
- Place the person on their side to keep airway open. Tip head slightly forward if it is possible that there is an obstruction is in the mouth.
- Check for individual plan and school policy for how long a seizure can continue before calling for emergency assistance.
- Document time and duration, and describe as objectively as possible.

Do not...

- Attempt to force anything into mouth or between teeth.
- Attempt to force mouth open.
- Attempt to stimulate by rubbing face, chest, or body.
- Attempt to move person from a position on the floor until seizure has run its course.
- Leave the seizure victim alone at any point during seizure.

Emphasize that there is nothing that they can do to stop a seizure, once it has begun it must run its course; and that as soon as a seizure has begun, if possible or as soon as possible, they should send for help. However, if the length of the seizure itself is unusual and outside the guidelines for safety prescribed by the district, or if the student appears to NOT be exchanging air adequately, emergency assistance should be sought. All seizure activity should be recorded as soon as possible and should be communicated to parents or caregivers.

Note to Instructor: Familiarize yourself with the guidelines regarding seizures and for seeking emergency medical assistance for the district the academy is being taught in.

2.6 Lecture Notes: Eating and the Heimlich Maneuver

In keeping with people-first language and maintaining the dignity of students, review the importance of using the term "eating," rather than "feeding." Encourage students to think about "eating" as the activity that the student is engaged in, while "feeding" is something that is done to someone.

Many students in special education settings need assistance with eating. This assistance may include reminders about table manners or actually feeding a student using a G-tube, having had appropriate training from the school nurse. Many students need special assistance in following mealtime plans prescribed by specialists that may be quite complex and/or could deal with issues such as:

- Positioning for best results, typically overseen or recommended by an OT or PT;
- Special recommendations regarding placement of food that may relate to an oral motor program, often prescribed by an OT or speech teacher;
- Allergic responses;
- Possibility of choking and consequent use of the Heimlich maneuver; and
- Appropriate utensil use (no plastic utensils for students who could injure

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themselves by using too strong of a bite, or who might have a bite reflex).

Paraeducators should always ask for pertinent information regarding a student's mealtime procedures if they are unfamiliar with the student and in the case that they will be physically assisting the student with the eating process.

Other things to keep in mind while assisting a student with eating:

- Meal-times are typically a time of socialization and enjoyment for most students. The paraeducator should make attempts to make this feel the same for the student with special needs and for peers who are eating lunch or snacks at the same time, attempting to assist the student in engaging in mealtime conversations with peers.
- Paraeducators should help maintain a student's dignity by keeping the face of the student that they are assisting cleared of food or fluid that might possibly be unappetizing to others.
- The paraeducator should present food to the student that is being assisted in an appetizing way, talking about what the student is eating and how the food might taste (not mixing foods together in a way that typical peers or onlookers might find unappetizing).

2.7 Lecture: Restroom and Privacy Issues

Paraeducators often assist students in use of the restroom. This may include the use of diapers or in teaching a student the steps toward independent use of the restroom. Paraeducators should communicate with supervising teachers regarding the procedures used in individual programs or schools for specific students and their needs. Privacy of the individual student should be observed and guarded while using the restroom.

When assisting a student who uses diapers, staff members should always use gloves. This should be done without exception. If gloves are not available, the staff member should request them.

If assisting a student who needs physical help pulling pants, pull-ups, or underwear up and down, a staff member should still use gloves. The use of gloves in this instance is not always recognized as essential, but there is often a high likelihood of coming in contact with unexpected "accidents" that would include urine or feces.

2.8 Lecture: Hand Washing

Hand washing is considered the quickest, easiest, and most effective means of controlling the spread of disease and contagions. Staff members should wash their hands, using soap, often, particularly after having physically engaged one student and before engaging another. This will help protect the students' health by not transferring germs and contagions from one student to the next, as well as, guard the staff member's health. Paraeducators should keep in mind that some students who have special needs also are medically fragile and need to be protected from infectious illnesses as much as possible.

2.9 Lecture: Catheterization

Some students use catheters as their primary mode of urination. They may need assistance with this process. Catheterization is typically considered a procedure covered under the nurse delegatory clause. Paraeducators need specific training from a school health official for a specific student, in order to assist with this procedure.

2.10 Lecture: Wheelchairs, Lifting, and Body Mechanics

There are several points to keep in mind when assisting a student who uses a wheelchair.

- If the student does not self-propel the wheelchair and requires the chair to be pushed, upon stopping, whether on a flat or inclined surface, brakes should always be set.
- When placing a student in a wheelchair, all safety belts and straps should be engaged.
- If a student uses a wheelchair as their primary mode of mobility and is seated in the chair for major parts of their school day, a therapist should be consulted regarding the most appropriate positioning to be used. Paraeducators should receive or request training specific to each student regarding how to assist them into and out of their wheelchairs.

When lifting a student in and out of a wheelchair, or any other type of equipment, paraeducators should be aware of the principles of good body mechanics. Using these principles will help avoid the potential injuries to themselves, as well as, increase safe transfers for the student. Distribute and review **Lifting and Good Body Mechanics** handout **(H6)**.

- Tell the student you are lifting what you are going to do.
- Always use a two-person lift for weights over 40 pounds.

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- Ask for assistance if you think that you need it.
- Bend your knees. Use your legs when lifting, not your back.
- Keep your feet well apart for a broad base of support.
- When turning, take small steps rather that twisting.
- When lifting with someone else, coordinate the lift by saying, "1, 2, 3, lift."

2.11 Lecture: Positioning

Very often students who have special needs have physical needs that are accommodated for throughout the school day. This may include the use of special adaptive equipment that is typically prescribed for use by a physical or occupational therapist. Paraeducators should receive specific training in the use of the special equipments for each student who needs to use them.

Goal 3: Know the obligation of all school personnel to report child abuse, suicidal ideation, and/or dangerous behavior.

3.1 Lecture: Child Abuse

Most school districts recommend that each building develop a process for handling child abuse that follow the legal guidelines of the state.

State guidelines require that upon having reasonable cause to know or suspect that a child has been subjected to abuse or neglect, ANY school employee with such knowledge or suspicion must immediately report those facts, or cause a report of those facts to be made to social services or law enforcement. If the abuse or neglect is observed in progress, the referral will be made immediately to the local law enforcement agency.

Distribute and review the **Reporting Child Abuse and Neglect** handout **(H7)**.

- Any school district employee must report known or suspected abuse or neglect.
- Persons with the knowledge must make the report or ensure that it is reported.
- If unsure, call social services and discuss it with them.
- Employees with the knowledge must complete forms.
- It is not the obligation of the employee to investigate.
- It is not appropriate for employees to contact the family of student.
- School personnel must cooperate with law enforcement in the case of an investigation.

Note to Instructor: Review district guidelines before teaching this portion. Check to see if the district has forms that it recommends for use for reporting or for keeping data, and, if so, make handouts and transparencies to further enhance the lecture.

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Goal 4: Know techniques that promote interactions and facilitate friendships among students with and without disabilities.

Note to Instructor: The information for the lecture comes from The Center on Human Policy, Personal Relationships Between People With and Without Disabilities, by Zana Marie Lutfiyya, found online at http://web.syr.edu/~thechp/relshp.htm.

4.1 Lecture: Development of Relationships

Briefly review the information from Module C regarding belonging and self-esteem, the higher levels of the Maslow's Hierarchy of Needs. Be sure to include Norman Kunc in the review.

Present the **Development of Relationships** transparency **(T8)**.

Opportunity
Too many people with disabilities have limited opportunities to take part in activities where they can meet their typical peers. This can be due to physical segregation or to being referred to as the "client" or a "special education student." Services may restrict people's chances to get together (program or funding rules, curfews, transportation and other restrictions). Whatever the reason, people with disabilities frequently become cut off and isolated from others.

Support
Throwing unsupported people together does not form relationships between people with and without disabilities. Some individuals need assistance in fitting into certain settings and activities, others may need someone to facilitate their involvement or to interpret them to others in positive ways. Without subtle supports, people with and without disabilities might never get a chance to really get to know each other.

Continuity
While we enjoy meeting new people, those we have known over time sustain us. The continuity of our relationships over the years is an important source of security, comfort, and self-worth. Many people with disabilities do not have continuous relationships, they may leave their families, be moved from one program to another, and have to adjust to staff people who come and go.

4.2 Lecture: Facilitating Relationships

Present the **Facilitating Relationships** transparency **(T9)**.

Bridge-Building
Facilitators who initiate, support, and maintain new relationships are called bridge-builders. They "...build bridges and guide people into new relationships, new places, and new opportunities in life." Bridge-builders involve people with disabilities in existing groups or with specific individuals.

Circles of Friends or Circles of Support
Groups of people who "meet on a regular basis to help a person with a disability to accomplish certain personal visions or goals." Circle members try to open doors to new opportunities, including establishing new relationships.

Citizen Advocacy
Recruited and supported by an independent citizen advocacy office, a citizen (advocate) voluntarily represents the interests of a person with a disability as if they were the advocate's own. Citizen advocates may take on one or several roles (e.g., friend, ally, mentor, protector) and some of these roles may last for life.

Note to Instructor: The following information was obtained from the British of Colombia Ministry of Education, Special Programs: Special Education. It can be located on the internet at: http://www.bced.gov.bc.ca/specialed/sid/40.htm.

Distribute the **Students with Intellectual Disabilities: A Resource Guide for Teachers** handout **(H8)**. Briefly review the handout, encouraging the participants to read it thoroughly outside of class and to keep as a personal reference for information regarding relationships. Emphasize that there are different ways that personal relationships between people with and without disabilities may be encouraged, and that perhaps more important than the specific method is the supporting, connecting role of one or more people (family members, staff members, friends, etc.) who can spend time and energy for this purpose.

Friendships are vital to the development of all young people. Friendships in school have academic as well as social benefits. For some children, friendships are a way to improve their communication, cognitive, and social skills. In order to help facilitate these areas of development a paraeducator or teacher can:

- Pay close attention to seating arrangements.
- Use cooperative-based groups in which students are encouraged to support one another.

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- Conduct awareness sessions with students.
- Serve as a model of how to interact with the student.
- Comment positively on any social interactions between the student and his/her peers.
- Use role-playing and other techniques to help students develop needed social skills.
- Help schedule the student in extracurricular activities.
- Invite the student to have lunch and have two or three other students join you.
- Recruit two or three students in the class to show the student the ropes and provide support when needed.
- Explain to the class why friendships are important.
- Participate in teacher inservices on friendship building.
- Assist peers in developing friendship problem-solving skills.
- Hold a weekly classroom forum.
- Teachers and paraeducators can encourage peers in interacting with the student.

4.3 Activity: Further Understanding Relationships

Paraeducators will participate in an activity which will enhance their understanding of the facilitation of relationships.

4.3.1 Steps

- Divide into small groups.
- Have the groups list ways in which they are currently facilitating relationships.
- Have the groups make another list of new techniques they would like try to facilitate relationships, or ways in which they could enhance what they are currently doing.
- Have the groups list success stories about relationships that have been built in their school communities.
- When finished, have the groups share their lists with the class.

Module D Handouts

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Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities

1. Know written health, safety, and emergency procedures and practices.

2. Know responsibilities and practices associated with maintaining the physical health and safety of students.

3. Know the obligation of all school personnel to report child abuse, suicidal ideation, and/or dangerous behavior.

4. Know techniques that promote interactions and facilitate friendships among students with and without disabilities.

Common Misconceptions About the Transmission of Bloodborne Pathogens

Research shows that the risk of getting a significant contagious disease in a school setting is extremely small. However, school staff need to decrease the possibility of exposure to bloodborne pathogens.

Significant contagious diseases (SCD) includes cytomegalovirus (CMV), hepatitis B virus (HBV) and human immunodeficiency virus (HIV) infections.

None of These are Modes for Transmission for Bloodborne Pathogens:

- Sharing Restrooms
- Bathroom Fixtures
- Drinking Fountains
- Hugging
- Eating with Carriers
- Mosquitoes
- Working and Studying with Carriers
- Playing with Carriers
- Swimming Pools
- Shaking Hands
- Eating Food Prepared by Carriers

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Universal Precautions

Universal Precautions means protecting oneself from exposure to blood or bodily fluids through the use of latex gloves, masks, or eye goggles; cleaning blood or bodily fluid spills with a soap and bleach solution and water; and disinfecting and incinerating or decontaminating infected water before disposing in a sanitary landfill.

Universal Precautions include:

- Attending to others.
  - Use a barrier when exposure to blood or body fluids is possible.
  - Bag soiled clothing.
  - Bag waste and used gloves or barriers.
  - Wash hands thoroughly.
- Attending to the environment.
  - Use gloves to clean.
  - Use disinfectant soaps.
  - Use disposable cleaning materials.
  - Disinfect affected areas.
  - Secure waste in bag for disposal.
- Attending to self.
  - Remove gloves and place in a plastic bag.
  - Immediately wash with disinfectant soaps.

The Five Rights of Assisting with Medication

1. ***Right Student:*** Protect confidentiality. Is this the right student? Even if you think you know the student to whom you are giving the medication, double-check by asking his/her name or have another method of verification.

2. ***Right Medication:*** Make sure that you are giving the right medication. Compare the prescribing practitioner's written instructions to the medication log and the pharmacy label. Check expiration dates.

3. ***Right Dosage:*** Be sure to give the exact amount of medication specified by the legal prescribing practitioner's orders and the pharmacy label. The dosage on the medication bottle and the authorization should agree.

4. ***Right Time:*** Check the medication log for the time when the medication should be given and to determine if it has already been given that day.

5. ***Right Route:*** Check the medication order and the pharmacy label for the method, indicating the exact route for the medication to be given (e.g., by mouth, by injection).

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Management of Seizures

Do...

- Lower person to the floor. If in a wheelchair, unstrap feet and loosen other straps, wait for assistance before removing from chair to floor.
- Loosen tight clothing that might interfere with breathing.
- Time the seizure and be observant of physical movement.
- Place the person on their side to keep airway open. Tip head slightly forward if it is possible that there is an obstruction is in the mouth.
- Check for individual plan and school policy for how long a seizure can continue before calling for emergency assistance.
- Document time and duration, and describe as objectively as possible.

Do not...

- Attempt to force anything into mouth or between teeth.
- Attempt to force mouth open.
- Attempt to stimulate by rubbing face, chest, or body.
- Attempt to move person from a position on the floor until seizure has run its course.
- Leave the seizure victim alone at any point during seizure.

Lifting and Good Body Mechanics

- Tell the student you are lifting what you are going to do.
- Always use a two-person lift for weights over 40 pounds.
- Ask for assistance if you think that you need it.
- Bend your knees. Use your legs when lifting, not your back.
- Keep your feet well apart for a broad base of support.
- When turning, take small steps rather that twisting.
- When lifting with someone else, coordinate the lift by saying, "1, 2, 3, lift."

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Reporting Child Abuse and Neglect

- Any school district employee must report known or suspected abuse or neglect.
- Pesons with the knowledge must make the report or ensure that it is reported.
- If unsure, call social services and discuss it with them.
- Employees with the knowledge must complete forms.
- It is not the obligation of the employee to investigate.
- It is not appropriate for employees to contact the family of student.
- School personnel must cooperate with law enforcement in the case of an investigation.

Students with Intellectual Disabilities, A Resource Guide for Teachers

Friendships are vital to the development of all young people. Friendships in school have academic as well as social benefits. For some children, friendships are a way to improve their communication, cognitive, and social skills. In order to help facilitate these areas of development a paraeducator or teacher can:

- Pay close attention to the seating arrangement. Place a student who is at risk of being isolated in the front of the room, next to peers who will be supportive. Avoid designating space to be used only by students with disabilities.
- Use cooperative base groups in which students are encouraged to support one another. Use a partner system in class. Rotate partners on a monthly basis, carefully selecting the partner for the student with special needs.
- Conduct awareness sessions with students to help dispel myths about people with disabilities. Encourage students to see the value in each person.
- Serve as a model of how to interact with the student, demonstrating respect for the student. For example, avoid talking about the student in front of him/her unless he/she is included in the conversation, let a student know he/she is welcome, show your acceptance of differences and openness in problem solving.
- Comment positively on any social interactions between the student and his/her peers.
- Use role-playing and other techniques to help students develop needed social skills.
- Help schedule the student into extracurricular activities.
- Invite the student to have lunch and have two or three other students join you.
- Recruit two or three students in the class to "show the student the ropes" and provide support when needed.
- Explain to the class why friendships are important.
- Participate in teacher inservice on friendship building.
- Assist peers in developing friendship problem solving skills.
- Hold a weekly classroom forum, a time when students can feel free to discuss problems and ways to improve the classroom climate.

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Students with Intellectual Disabilities, A Resource Guide for Teachers
(continued)

Teachers and paraeducators can encourage peers to:

- Arrange to join the student for lunch on certain days.
- Say hello in the halls. Provide encouragement and understanding in stressful situations.
- Talk to the student, particularly when the student is alone. Help the student get to know the environment.
- Invite the student to join a club or activity. Become a peer helper. Prompt the student on ways to behave appropriately.
- Call the student on the telephone.
- Go out of their way to sit with the student on the bus.
- Become a part of the student's circle. This helps to make sure the student becomes a part of the school.
- Help the student get around the school. Walk with the student to class.
- Arrange to sit next to the student in class and to help out whenever needed.
- Encourage friends to welcome this student into the group.
- Share a locker with the student.
- Learn more about the student. For example, learn how to communicate through basic sign language, how to operate a wheelchair safely and what some of the student's likes and dislikes are.

Source: This article is from the British of Colombia Ministry of Education, Special Programs: Special Education. It can be located on the internet at: http://ww.bced.gov.bc.ca/specialed/sid/40.htm

Module D Transparencies

Module D: Health, Safety, Physical, and Belonging Needs of Students with Disabilities

OrSpedD-T1

- ***Know written health, safety, and emergency procedures and practices.***

- ***Know responsibilities and practices associated with maintaining the physical health and safety of students.***

- ***Know the obligation of all school personnel to report child abuse, suicidal ideation, and/or dangerous behavior.***

- ***Know techniques that promote interactions and facilitate friendships among students with and without disabilities.***

Delegation

If a nurse delegates a procedure to a paraeducator, the nurse is still ultimately responsible.

Incident Report

When an incident occurs at school, or on the school grounds, you may be asked to fill out an incident report.

The report should include:

- ***Nature of the Incident;***
- ***Any First-Aid Given;***
- ***Time, Place, and Date of Incident;***
- ***A Description of the Injury or Incident; and***
- ***Any Follow-up Care Given.***

Responsibilities and Practices

- ***Universal Precautions***
- ***Delivery of Medication***
- ***Seizures***
- ***Eating and the Heimlich Maneuver***
- ***Restroom and Privacy Issues***
- ***Hand Washing***
- ***Catheterization***
- ***Transportation and Wheelchairs***
- ***Lifting and Good Body Mechanics***
- ***Positioning***

Common Misconceptions About the Transmission of Bloodborne Pathogens

- ***Sharing Restrooms***
- ***Bathroom Fixtures***
- ***Drinking Fountains***
- ***Hugging***
- ***Eating with Carriers***
- ***Mosquitoes***
- ***Working and Studying with Carriers***
- ***Playing with Carriers***
- ***Swimming Pools***
- ***Shaking Hands***
- ***Eating Food Prepared by Carriers***

Universal Precautions

Attending to Others

- *Use a barrier when possible exposure to blood or bodily fluids.*
- *Bag soiled clothes.*
- *Bag waste and used gloves or barrier.*
- *Wash hands thoroughly.*

Attending to the Environment

- *Use gloves to clean.*
- *Use disinfectant soaps.*
- *Use disposable cleaning materials.*
- *Disinfect affected area.*
- *Secure waste in bag for disposal.*

Attending to Self

- *Remove gloves and place in plastic bag.*
- *Immediately wash with disinfectant soap.*

The Five Rights of Assisting With Medications

OrSpedD-T7

1. ***Right Student***

2. ***Right Medication***

3. ***Right Dosage***

4. ***Right Time***

5. ***Right Route***

Development of Relationships

- ***Opportunity***
- ***Support***
- ***Continuity***

Facilitating Relationships

- ***Bridge-Building***
- ***Circles of Friends or Circles of Support***
- ***Citizen Advocacy***